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END-OF-PROJECT EVALUATION OF THE INDONESIA FAMILY PLANNING DEVELOPMENT AND SERVICES II PROJECT

by

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Fieldwork
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Glossary

A.I.D.	U.S. Agency for International Development
ASEAN	Association of South East Asia Nations
AVSC	Association for Voluntary Surgical Contraception
BAPPENAS	Department of Education and the Office of Overseas Training
BKKBN	Indonesian National Family Planning Coordinating Board
CBD	community-based distribution
CPR	contraceptive prevalence rate
CSM	contraceptive social marketing
DOH	Department of Health
FPDS II	Family Planning Development and Services II (project)
FY	fiscal year
GOI	Government of Indonesia
IBI	Indonesian Midwives Association
IDI	Indonesian Doctors Association
IEC	information, education, and communication
INCPS	Indonesian National Contraceptive Prevalence Survey
IDHS	Indonesian Demographic and Health Survey
ISFI	Indonesian Pharmacists Association
IUD	intrauterine device
KB Mandiri	family planning self-sufficiency
MIS	management information system
MMT	modern management technology
NGO	non-governmental organization
PIL	project implementation letter
PIO/C	project implementation order/commodity
PIO/P	project implementation order/participant
PIO/T	project implementation order/technician
PKLM	family planning field worker
PPLKB	family planning supervisor at puskesmas
PKMI	Indonesian Society for Secure Contraception
PUBIO	Center for Biomedical and Human Reproduction Research, BKKBN
PUJAK	Center for National Family Planning Policy Development, BKKBN
PUKOM	Center for Computers and Data, BKKBN
PUSDIKLAT	national training center
PUSIK	Center for National Family Planning Studies, BKKBN
puskesmas	sub-district health center
RAM	repair and maintenance (center)
Rp.	Rupiah (Indonesian currency)
SOMARC	Social Marketing for Change (project)
SPSS	Statistical Program for the Social Sciences
USAID	U.S. Agency for International Development (mission)
VCDC	village contraceptive distribution center
VFP	village family planning
VS	voluntary sterilization
YKB	Yayasan Kusuma Buana (Indonesian non-governmental organization)

Project Identification Data

1. Scope: Indonesia

2. Project Title: Family Planning Development and Services II

3. Project Number: 497-0327

4. Critical Project Dates:

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Amendment l:	07-26-83	($ 3,900,000)
Amendment 2:	06-10-87	($ 6,000,000)
Amendment 3:	08-22-87	($ 7,000,000)
Initial Obligation:	FY 1983	
Final Obligation:	FY 1987	
Project Assistance Completion Date:	12-31-91	

5. Project Funding:

A.I.D. Bilateral: $19,200,000 - grant
$17,200,000 - loan

6. Mode of Implementation:

A.I.D. Bilateral: Host country through PIO/Ts for buy-ins to the Bureau for Research and Development, Office of Population contracts and cooperative agreements; PIO/Cs for commodities; PIO/Ps for international training.

7. Project Designers: USAID/Indonesia and Government of Indonesia's National Family Planning Coordinating Board.

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9. Previous Evaluations/Reviews:

Village Family Planning Component:	July 15, 1987
Urban Family Planning Component:	July 18, 1989
Voluntary Sterilization Component:	August 3, 1989
Modern Management Technology Component:	October 5, 1988
Training Component:	September 1986 and December 1990
Research and Development Component:	February 1988

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Executive Summary

Introduction

The eight-year Family Planning Development and Services II Project provided $36.4 million to support efforts of the Indonesian National Family Planning Board (BKKBN) to increase contraceptive prevalence and to strengthen the institutional capability of BKKBN to plan, manage, and evaluate an expanding national family planning program. The project purpose was to increase contraceptive prevalence from an estimated 43 percent of married couples in December 1982 to 58 percent by March 1987; this was later raised to 69 percent by December 1992. After the 1987 Indonesia Contraceptive Prevalence Survey showed lower rates of contraceptive prevalence than had been originally estimated in 1982, BKKBN modified its targets to 50 percent prevalence by 1992 and 53 percent by 1994.

Overall, this has been a highly successful project in support of a highly successful national family planning program which has received international acclaim for its achievements, innovative approaches, and dynamic leadership. During the 1980s, contraceptive prevalence nearly doubled from 26 percent to 50 percent, even while the pool of women of reproductive age increased substantially. The total fertility rate has declined from 5.6 children per woman in 1970 to 3.0 children in 1991. Five provinces (East Java, Bali, Yogyakarta, Jakarta, and North Sulawesi) now have total fertility rates of 2.1 children or lower, that is, replacement level fertility. The percentage of couples utilizing the private sector for their contraceptives nearly doubled between 1987 and 1991, from 12 to 22 percent of married couples of reproductive age. The increase occurred during the same period USAID provided extensive support for private sector providers of family planning.

Project Implementation

The FPDS II project was divided into six components. Three components were designed to expand and improve family planning services and three components were aimed at strengthening BKKBN's institutional capacity to manage an increasingly large and complex national program.

Village Family Planning Component. The village family planning component provided $7,054,000 to expand village and sub-village level delivery of family planning information and contraceptives utilizing village volunteers in sub-districts with low contraceptive use in 18 provinces and to initiate activities to promote family planning self-sufficiency (KB Mandiri) by encouraging couples to pay for contraceptives. KB Mandiri pilot projects have been completed successfully in three provinces. By project end, the BKKBN will have over 300,000 field workers and village volunteers trained and in place nationwide to provide family planning information and contraceptives. In the future, BKKBN plans to train up to 10,000 midwives at the village level annually in response to demands for more professional family planning services at the village level.

There was a problem in measuring the anticipated project impact in low-prevalence sub-districts identified in the project paper. The BKKBN proposals and A.I.D. PILs did not allocate funds precisely for activities in those sub-districts. Furthermore, BKKBN service statistics did not give an accurate picture of contraceptive prevalence and the 1987 INCPS did not even measure prevalence on a provincial level for the outer islands provinces, thereby eliminating a potential baseline for later analysis.

Although KB Mandiri activities were initiated in three provincial pilot projects, both the evolving nature of this concept as it relates to public sector delivery of family planning services and the lack of clear operational guidelines to the field made it difficult for field staff to articulate and operationalize KB Mandiri within the existing village family planning system.

Urban Family Planning Component. The urban family planning component provided $7,250,000 to support special programs whose aim was to increase the number of private providers trained and to offer family planning information and contraceptives on a fee-for-service basis. These initiatives were part of efforts to shift the costs of the program from the government budget to individuals or communities. At project start, BKKBN was grappling with the need for an urban strategy to bring urban contraceptive use up to the high levels already achieved in rural areas. USAID and the A.I.D. Office of Population combined resources to initiate the Dua Lima condom social marketing program and the Blue Circle information and training program for private doctors, midwives, and pharmacists, as well as the public, and followed up with promotion of the Blue Circle line of contraceptives. This has been the most innovative component of the project and has had the most influence on BKKBN policy. Private providers may now distribute and sell Blue Circle contraceptives and these contraceptives may be advertised by brand name in the public media.

Some of the problems encountered in expanding urban family planning activities included confusion about the meaning of Blue Circle (whether it is a generalized concept for many family planning activities or a set of contraceptives sold through private providers); some decrease in efficiency due to involvement of more organizations in the participatory management of family planning services; inconsistencies between public and private sector bureaucracies in promotion of private sector family planning; concerns about the feasibility and economic soundness of extending contraceptive social marketing (CSM) distribution beyond the largest cities; and the potential threat to profitability of Blue Circle products from the sales of "free" contraceptives by government doctors and midwives.

Voluntary Sterilization Component. The voluntary sterilization component provided $7,882,000 for renovation of 380 hospitals and 230 sub-district health clinics, clinical equipment, and medical supplies; trained 386 doctor and paramedical teams from hospitals and 331 teams from sub-district health clinics in voluntary sterilization surgical techniques; supported the design and implementation of improved patient counseling and trained 1,060 counselors; and trained 240 field workers, 2,019 staff members of BKKBN and MOH, and 148 community leaders. Support from the project and Office of Population contractors assisted the Indonesian Society for Secure Contraception (PKMI) to develop and implement a system of quality assurance review teams and procedures at the hospital, provincial, and national levels for review of medical complications. This is another important policy change for which the project can take much credit.

Among the major problems encountered in implementation of this component were the high cost of voluntary sterilization (VS) for many couples even though BKKBN provides some subsidy to service providers; the need to expand services to fill what appears to be a significant unmet demand; lack of information on VS by nearly half of all married women of reproductive age; wide variation in clinic utilization of VS with 20 percent of clinics performing 80 percent of all VS procedures; frequent transfers of health center doctors resulting in a continual need for VS training; continued heavy dependence on donor resources by PKMI; limited Government of Indonesia (GOI) funds for provincial quality assurance teams to monitor VS clinics and slow development of hospital internal quality assurance review committees; continuing concern that BKKBN's push for expansion will lead to lower quality of services and potential long-term negative consequences for the VS program; and

the restrictions on salary levels for repair and maintenance (RAM) center staff which make it difficult to retain staff.

Modern Management Technology Component. The modern management technology component provided $1,948,000 for over 130 computers, software and training for staff at BKKBN headquarters and provincial offices, as well as regency offices in West Java. Previously, BKKBN had only one computer at headquarters to produce periodic reports on family planning service statistics, logistics, and finance. With the equipment and training provided by USAID, all headquarters offices and the provincial offices now have the capability to utilize existing data for special analysis. Success of the USAID project has resulted in World Bank funding support for approximately 200 additional computers for the remaining regencies.

Major problems encountered during implementation of this component include the difficulty in staffing provincial offices with trained computer specialists; the limited utilization of existing computer capability at provincial levels for program management and research purposes; and the continued dependence on donor funding for computer hardware and software.

Training Component. The training component provided $9,366,000 for graduate-level degree training in the U.S. and Indonesia, as well as short-term training in the U.S. and limited support to BKKBN to establish an International Training Center for the many foreign visitors wishing to learn about the Indonesian national family planning program. Significant numbers of persons, mainly BKKBN staff, were sent to the U.S. for graduate-level training and even larger numbers were sent to Indonesian universities for bachelor, master, and doctoral degrees. Compared with other Indonesian government agency long-term training programs, the December 1990 *Input Evaluation of the Project* found that BKKBN had a much larger proportion of participants who did not receive their degrees.

The BKKBN training program has succeeded as well as it has only with the help of a full-time U.S. advisor. There are a number of policies and procedures that need to be improved. It appears that the World Bank will become the main support for long-term training for BKKBN staff and training will be expanded to include European and Australian universities as well as U.S. This will compound existing problems at BKKBN to manage long-term training.

Other problems remaining to be resolved include the inefficient monitoring mechanisms for overseas participants and the poor match between training and future job responsibilities.

Research and Development Component. The research and development component provided $2,900,000 to support local research. Fifty-one research projects were completed as well as the 1987 Contraceptive Prevalence Survey. BKKBN contracted out 60 percent of the studies and undertook 40 percent in-house. There was substantial expatriate and Indonesian technical assistance provided to the BKKBN Bureau of Research, as well as in-house and long-term staff training. BKKBN has traditionally utilized research to test new approaches to service delivery and has adjusted national policy based on the results.

The research component was hampered by continuing problems with both the quantity and quality of staff; inefficient administration among the three research centers; inadequate coordination between operational units of BKKBN and the research unit; poor quality of extramural research proposals; and a poorly defined research focus for BKKBN.

Lessons Learned

1. Privatizing family planning services seems to work best when initiated on a small scale in a limited market with a few contraceptives and then expanded to a wider market with a broader array of contraceptives based upon the initial experience.

2. Social marketing campaigns tend to be most successful when the private sector experts are allowed to make market decisions. At the same time, private sector providers require substantial stimulus to encourage their participation.

3. Social marketing can utilize existing systems of family planning service delivery as well as previously existing but unused or underutilized delivery systems.

4. A large number of service points with trained staff is essential for widespread use of most long-term methods. The exception appears to be voluntary sterilization, for which higher quality of service in a limited number of service points may be a more important factor in increasing the number of clients than a large number of service points.

5. Establishing a sound quality assurance system is a long-term process with a substantial training component to meet the specific needs of professionals at each organizational level. The most difficult level at which to introduce a quality assurance monitoring system is the individual hospital or clinic where staff are reviewing and monitoring performance of peers.

Conclusions

General

1. The prospects for sustainability of Indonesia's national family planning program are exceptionally good, especially with the new emphasis on fee-for-service which will reduce the government's budget burden and increase individual involvement and commitment to the program.

2. Indonesia is well on its way toward achieving replacement level fertility within the next decade.

3. The rapid increase in the share of couples seeking contraceptive services through the private sector between 1987 and 1991 offers good evidence of the potential for this market.

4. The project contributed to several important policy changes by the GOI: 1) authorization for doctors and midwives to sell and dispense contraceptives, which made possible the planned introduction of Blue Circle commodities and use of doctors and midwives as the primary distributors; 2) authorization to advertise Blue Circle contraceptives by brand name through the mass media, which has helped establish Blue Circle products as market leaders; and 3) the development and implementation of a multi-tiered system of quality assurance for voluntary sterilization, which has helped remove some of the impediments to the VS program by assuring the public and policy leaders that VS is a safe and carefully monitored program.

5. USAID and BKKBN recognition that the bilateral family planning project was part of Indonesia's national family planning program and was not viewed as a "USAID project" helped create a collaborative working relationship.

6. Long-term technical assistance advisors have played an important role in most of the project components to assist with project implementation and transfer of technical skills to Indonesian counterparts.

7. The availability of additional resources through Office of Population worldwide contractors and grantees for technical assistance and operational activities has enhanced USAID's ability to support BKKBN in development of new program initiatives.

8. Additional accounting requirements have led to delays in processing funding requests and have increased BKKBN concern that USAID procedures and projects will be less flexible in meeting requirements of a dynamic and changing program.

Village Family Planning

9. There is a need for better baseline data in setting project objectives in order to carefully assess the results.

10. The various activities to shift the financial burden for family planning services from the government to individuals merit careful documentation, for examination by both Indonesia and other countries.

Urban Family Planning

11. There appears to be great potential for expansion of the concept of KB Mandiri in both urban and rural areas. The percent of couples purchasing contraceptives through the private sector nearly doubled between 1987 and 1991 and now represents 22 percent of current contraceptive users.

12. BKKBN's push to have Mecosin (the program's market managers) expand the CSM program to 301 cities may increase costs to the point where it is no longer profitable for the private sector to participate.

Longer-Term Methods

13. The MOH, BKKBN, and PKMI could be more aggressive in promoting VS to reach the apparently large unserved market, consistent with internal cultural and religious constraints. The total number of VS procedures annually appears to fall far short of potential demand based upon responses to the 1987 and 1991 prevalence surveys.

14. Use of contraceptive implants is the fastest growing method now used in Indonesia. However, the implant program faces serious medical issues in all aspects of the program: training, standardization, evaluation, and quality assurance.

Modern Management Technology

15. Training in computer utilization for program managers at the provincial and regency levels would encourage them to make productive uses of data already at their command.

16. There exists a continuing concern with the quality of data reported through BKKBN's monthly service statistics collection system.

Training

17. Exposure to new ideas and concepts was generally held to be beneficial by trainees and BKKBN leadership, and opportunities for training, especially in the U.S., are generally sought after.

18. There is a continuing need for BKKBN staff upgrading, particularly as the program deals with new concepts such as KB Mandiri and emphasis on the private sector.

Research and Development

19. The Bureau of Research will not likely fulfill its important role within BKKBN unless staffing is expanded and its quality improved.

20. The planning and management of research within BKKBN is scattered and not coordinated in a manner that would achieve more effective utilization of funds and limited technical staff.

Recommendations

Staying the Course

1. USAID should continue to provide assistance to the Indonesia family planning program in areas of mutual interest with BKKBN. Such assistance could play an important part in helping Indonesia reach its desired demographic goals over the next decade.

Village Family Planning

2. USAID should consider offering limited technical assistance to assist BKKBN in documenting current efforts to shift the financial burden for family planning services from the government to individuals.

Urban Family Planning

3. Future USAID assistance should continue to support expansion of CSM initiatives in the larger urban areas through technical assistance, training and substantial support for program activities, especially local currency costs of advertising, promotion, and marketing of products.

Voluntary Surgical Contraception

4. USAID should continue to provide technical assistance in the areas of quality assurance, expansion of services, and increasing the use of private sector physicians.

Quality Assurance for Implants

5. It is essential that BKKBN and the Ministry of Health establish an independent organization for implants, similar to PKMI for voluntary sterilization, to establish standards of care, provide field surveillance, develop peer review committees, assist in training of providers, and monitor program implementation.

Modern Management Technology

6. USAID should consider using funds for limited technical assistance in modern management technology as new opportunities for greater use of computers are identified or for assistance in the evaluation of current computer programs.

Training

7. USAID should fund expatriate technical expertise to assist BKKBN staff in management of overseas training, but only if USAID plans to be a major provider of long-term overseas training; otherwise the technical assistance should be provided by the World Bank or other major donor. Any future assistance should be conditioned upon improvements in the existing selection processes and internal BKKBN procedures.

8. USAID should encourage BKKBN to provide more short-term training to staff in new areas such as KB Mandiri and privatization of services.

Research

9. USAID should provide some technical assistance and long-term training for staff of the Bureau of Research, but only after BKKBN has developed a plan to coordinate the management of research.

10. USAID or an A.I.D. contractor should consider funding continuing research on several current problems, such as investigation of the causes of the slow growth in contraceptive prevalence between the 1987 and 1991 surveys in order to increase future prevalence rates and field studies to test implementation of KB Mandiri.

1. Introduction

1. Introduction

1.1 General Background

The Government of Indonesia created the National Family Planning Coordinating Board (BKKBN) in 1970 to spearhead efforts to reduce high rates of population growth. During the intervening 21 years, the Indonesia national family planning program has achieved stunning success, has gained worldwide recognition for its innovative approaches to bring family planning information and services to the people, and has become almost completely self-reliant in terms of contraceptive manufacture and supply.

With over 180 million inhabitants, Indonesia ranks as the world's fifth most populous nation. The national family planning program is concerned with the rate of population growth, its density and distribution, and quality of life for the Indonesian people. Long recognized as a leader in providing information and services to rural populations, BKKBN has, in recent years, given increasing focus to the needs of urban couples as well, and has attempted to shift the burden of program costs from the government to clients through greater use of private sector providers. Strong and continuous political support, an innovative and dynamic BKKBN, and a decentralized, village-based program are major factors contributing to program success.

1.2 The Family Planning Development and Services II Project (FPDS II)

1.2.1 Project Description

A.I.D. began its assistance to the Government of Indonesia (GOI) in the late 1960s and has been one of the major donors to BKKBN for the past 20 years. Three previous bilateral projects helped build a basic family planning organization, supported expansion of services nationwide, and provided massive quantities of contraceptives. FPDS II shifted emphasis to assist BKKBN in meeting new challenges in moving toward national implementation of a mature family planning program. The project paper described these new challenges as increasing contraceptive prevalence in low-performing areas; utilizing the private sector in the delivery of services; increasing BKKBN's institutional capability through training and technical assistance; accelerating decentralization of program planning, implementation, administration, and evaluation; and utilizing flexible funds to encourage BKKBN to try innovative approaches to expanding services.

The FPDS II project was originally designed as a five-year $25.2 million project; however, the USAID mission director at that time decided to limit the amount and duration. Thus, the original FY 1983 authorization was for a $19.5 million three-year project. Three project amendments, one in FY 1983 and two in FY 1987, increased total funding to $36.4 million over an eight-year period. U.S. Congressional requirements during this period stipulated that A.I.D. funds must include a certain portion of loans. The project was almost evenly divided between grant ($19.2 million) and loan ($17.2 million) funds.

FPDS II included six components, three of which focused on strengthening BKKBN's capacity to expand family planning service delivery:

- village family planning,
- urban family planning, and
- voluntary sterilization.

The remaining three components were designed to strengthen BKKBN's management, administrative, and analytical capability:

- modern management technology,
- training, and
- research and development.

1.2.2 Project Objectives

The overall objective of the project was to assist the BKKBN in meeting its goal of increasing contraceptive prevalence from an estimated 43 percent of married women of reproductive age in December 1982 to 58 percent by March 1987. In the 1987 project amendment, this objective was changed to meet the new BKKBN goal of 69 percent prevalence by December 1992.

1.3 Evaluation Scope of Work

According to the evaluation scope of work, the team was to

1. Measure the accomplishments of project objectives for the six components of the project. This was to include

   a) an assessment of the expansion and improvement of family planning services with regard to the expansion of village family planning services; the development of urban family planning programs; and the upgrading of the quality of voluntary sterilization services and the development of a private sector voluntary sterilization network.

   b) an assessment of the impact of the project on the strengthening of BKKBN's institutional capability to plan, manage and evaluate its program through the introduction of modern management technology; long- and short-term training (both in-country and overseas) relevant to family planning management and technical skills improvement; and support of research and development.

2. Identify lessons learned from the project which can/are being applied to USAID's current Private Sector Family Planning project (Project 0355), and analyze the contribution(s) of this project to the overall national family planning program.

See Appendix A for the complete scope of work.

1.4 Evaluation Team

A team of two international consultants was contracted through the Population Technical Assistance Project (POPTECH). Plans to include an Indonesian professional were set aside at the last minute by contracting problems. The team included Charles Johnson, a family planning and population program advisor who served as team leader, and Eve Epstein, a management and administration specialist. The team arrived in Jakarta on November 3, 1991; Ms. Epstein left the country on November 17 and Mr. Johnson on November 22.

1.5 Evaluation Methodology

Given the limited time available, and the small team, the evaluation consisted largely of reviewing background documents and interviewing officials at BKKBN and USAID, technical assistance consultants, and some non-governmental organization leaders. Fortunately, there were comprehensive midterm evaluations of each of the six project components in 1988 or 1989. The reader should refer to these six midterm evaluations for detailed descriptions of the project components and accomplishments. The present evaluation attempts to summarize major accomplishments, problems encountered, problem resolution, and general lessons learned over the entire eight-year project period.

2. Overview of Project Accomplishments

2. Overview of Project Accomplishments

FPDS II was a successful project supporting a highly successful national family planning program. During the 1980s, contraceptive prevalence nearly doubled from 26 percent (1980 national census figure) to 50 percent, even while the pool of women of reproductive age increased substantially. The project served as the major source of support for privatizing family planning services, for expanding the availability of and raising the quality of voluntary sterilization services, for international training for staff of BKKBN and supporting institutions, for introducing computer technology to provincial BKKBN offices, and for developing an International Training Center at BKKBN to meet the increasing demand from other countries to learn about the Indonesian family planning program. The project also made major contributions to expanding village and urban family planning services and encouraging research to support policy and program changes. In each of the six project components, most quantitative project objectives were reached or exceeded. Any problems noted in the evaluation must be considered in the context of the overall successful implementation of the project.

There is one significant problem in measuring project impact. As stated in Section 1, the project objective was to increase contraceptive prevalence from an estimated 43 percent of married couples of reproductive age in December 1982 to 58 percent by March 1987; in the 1987 project paper amendment, this was raised to 69 percent by December 1992. These target contraceptive prevalence levels were set based on the best available estimates at the time which, in turn, were based on BKKBN service statistics (these statistics indicate new acceptors and ever users but not current users of contraceptives). However, the 1987 Indonesian National Contraceptive Prevalence Survey (INCPS) found contraceptive prevalence to be only 48 percent and preliminary results of the 1991 Indonesian Demographic and Health Survey (IDHS) indicate an increase to 50 percent. BKKBN service statistics indicated a 67 percent prevalence rate by mid-1991. Acknowledging the substantial gap between the two systems of measuring prevalence, the BKKBN is examining ways of refining its service statistics and institutionalizing the periodic prevalence surveys to corroborate program results independently. As a result of the INCPS findings, the BKKBN reduced the contraceptive prevalence objectives in the 1989-94 five-year plan to 50 percent by 1992 and 53 percent by 1994. Although the FPDS II project purpose was not formally revised to match the new BKKBN objectives, all subsequent assessments of project progress have incorporated the revised contraceptive prevalence levels.

The 1991 IDHS highlights a dramatic increase in family planning services provided through private sector channels from 12 percent in 1987 to 22 percent in 1991, roughly the same period of A.I.D.-supported efforts to expand private sector family planning services. Total fertility declined from 5.6 children per woman in 1970 to 3.0 children in 1991, and five provinces now have total fertility rates of 2.1 children or lower, representing replacement level fertility. Although the increase in contraceptive prevalence between 1987 and 1991 is small, it is important to note that the numbers of women of childbearing age increased by one million over those same years. BKKBN is faced with the continual challenge of expanding services rapidly to maintain current prevalence levels because of the rapid increase in the number of women of reproductive age, the result of previous high fertility.

Data from the 1990 national census provide additional corroboration of the demographic changes that have occurred in Indonesia during the 1980s. The average annual population growth for the decade declined to 1.9 percent with striking variations between urban and rural areas. The overall population

growth rate was 1.7 to 1.8 percent in 1991. Urban population increased 5.36 percent annually during the decade while the rural population grew a mere 0.79 percent annually. While the rural population increased from 114 to 124 million, the urban population jumped from 33 to 55 million. Much of this was due to migration from rural areas to the cities.

3. Expansion and Improvement of Family Planning Services

3. Expansion and Improvement of Family Planning Services

3.1 Village Family Planning Component

3.1.1 Component Objectives

The project paper authorized $5,054,000 for the village family planning (VFP) component, split between $899,000 in grant funds and $4,155,000 in loan funds. Amendment No. 1 to the project paper in 1983 added $1,000,000 in loan funds. Amendment No. 3 (1987) provided an additional $400,000 in grant and $600,000 in loan funds. Total USAID funding for this component was $7,054,000, including $1,299,000 in grant funds and $5,755,000 in loan funds.

The 1983 project paper outlined the following objectives for the VFP component:

- The number of family planning service points would be increased from 162,000 in March 1981 to 200,000 in March 1987.
- Resources would be concentrated in 1,673 low-performing sub-districts in the 13 high-priority provinces of West Java, Central Java, East Java, North Sumatra, West Sumatra, Lampung, South Sulawesi, Nusa Tenggara Barat, South Sumatra, Nusa Tenggara Timur, Aceh, Riau, and West Kalimantan. These 13 provinces included approximately 51,000 of Indonesia's 65,500 villages and 78 percent of non-contracepting married women of reproductive age.
- The VFP program would include strengthening or expanding the number of village or sub-village service points; education and training; pilot testing of new techniques or approaches; information and motivation services; strengthening management, logistics, and reporting capabilities and techniques; equipment and supplies; essential operating costs; supervision; and consultation support.

In Amendment No. 3 to the project paper (1987), funds were increased to permit expansion of VFP activities in additional low- and high-prevalence provinces, on a pilot basis. Five provinces were identified in project implementation letter (PIL) 119A (December 1988) to receive funds for standard family planning activities: East Kalimantan, Central Kalimantan, Irian Jaya, Maluku, and Central Sulawesi.

FPDS II initially supported BKKBN's efforts to introduce the new concept of KB Mandiri (family planning self-sufficiency) by providing funds in PIL 95 (July 1988) for a pilot project in the three provinces of Bali, Yogyakarta, and North Sulawesi. PIL 119A also included funds for a new VFP program in the 13 original provinces involving KB Mandiri approaches (the evaluation team did not have an opportunity to observe any results in these areas to date).

The project paper noted that the VFP component built upon nearly a decade of experience and the continuation of support was seen as "an excellent opportunity to build on this success by both continuing to spread its geographical reach into even more remote and difficult areas and to deepen its impact where the institutional framework is now available." Precise inputs in each province or lower administrative level would be based on an analysis of need, largely in accordance with the level

of contraceptive prevalence, responsiveness to family planning by local leadership and the villagers, and socio-economic conditions in the area.

3.1.2 Component Accomplishments

Number of Service Delivery Points. According to BKKBN statistics as of June 30, 1991, there were over 300,000 service delivery points nationally with over 23,000 paid field workers and supervisors to promote village family planning (see Table 1). These figures are substantially above the targets established in the project paper and amendments. There has also been a marked increase in the number of village and sub-village family planning outlets (see Table 2).

Table 1
Number of Service Delivery Points Nationwide
(as of June 30, 1991)

Type of Service Delivery Point	Number
Village Contraceptive Distribution Centers (VCDC)	65,385
Sub-Village Contraceptive Distribution Centers (Sub-VCDC)	230,698
Family planning field workers (PLKB)	19,010
Family planning supervisors at Puskesmas (PPLKB)	4,095

Table 2
Number of Village and Sub-Village Family Planning Outlets for Original 13 Target Provinces
(1982 and 1991)

Province	VCDC 1982	VCDC 1991	Sub-VCDC 1982	Sub-VCDC 1991
West Java (JB)	4,900	8,317	19,200	48,803
Central Java (JB)	6,700	8,404	32,200	47,094
East Java (JB)	9,400	8,121	34,100	43,206
North Sumatra (I)	1,700	5,170	3,000	16,233
West Sumatra (I)	3,500	3,817	—	2,886
Lampung (I)	1,500	1,876	5,600	9,814
South Sulawesi (I)	300	1,904	3,900	7,606
West Nusa Tenggara (I)	600	553	2,100	3,428
South Sumatra (I)	2,300	2,707	1,900	7,632
East Nusa Tenggara (II)	2400	1,511	—	1,527
Aceh (I)	2,300	4,830	2,100	2,250
Riau (II)	—	1,026	—	3,384
West Kalimantan (I)	1,300	1,157	4,600	3,926
Totals	34,900	49,393	108,700	197,789

Note: The designations JB, I, or II in parentheses following the provincial name indicate whether the provinces are included in the BKKBN groupings of Java-Bali, Outer Islands I, or Outer Islands II.

To strengthen even further the village family planning network and to respond to village women's requests for better trained and more professional family planning staff at the village level, BKKBN has announced plans to train up to 10,000 midwives annually. These will be women from the villages who, it is hoped, will remain in the villages and become important links in the expansion of Blue Circle contraceptive sales in the villages.

Contraceptive Prevalence Rates. For the original 13 target provinces, the contraceptive prevalence rate (CPR), according to BKKBN service statistics, are as follows:

Table 3
Contraceptive Prevalence Rates in Original 13 Target Provinces according to BKKBN Service Statistics (1983 and 1991)

Province	CPR-1983	CPR-1991
West Java (JB)	41%	59%
Central Java (JB)	54%	64%
East Java (JB)	65%	65%
North Sumatra (I)	45%	64%
West Sumatra (I)	37%	54%
Lampung (I)	39%	47%
South Sulawesi (I)	50%	52%
West Nusa Tenggara (I)	47%	58%
South Sumatra (I)	36%	64%
East Nusa Tenggara (II)	38%	47%
Aceh (I)	29%	65%
Riau (II)	14%	54%
West Kalimantan (I)	38%	62%

There is a substantial variance between the above CPR figures reported by BKKBN and contraceptive prevalence reported in the comparative figures for the 13 provinces in the 1987 INCPS and the 1991 IDHS. As seen in Table 4, the two surveys show lower contraceptive prevalence rates, with higher rates generally in 1991.

Table 4
Contraceptive Prevalence Rates
(according to 1987 INCPS
and 1991 IDHS)

Province	1987 INCPS	1991 IDHS
West Java (JB)	45.8	51.0
Central Java (JB)	53.5	49.7
East Java (JB)	49.8	55.4
North Sumatra (I)	NA	37.2
West Sumatra (I)	NA	40.3
Lampung (I)	NA	53.8
South Sulawesi (I)	NA	37.1
West Nusa Tenggara (I)	NA	39.0
South Sumatra (I)*	NA	47.2
East Nusa Tenggara (II)*	NA	39.2
Aceh (I)*	NA	28.9
Riau (II)*	NA	39.8
West Kalimantan (I)*	NA	44.4

* These provinces were described in the project paper as "administratively and topographically more difficult" and village family planning was expected to cover only 50 percent of the villages and sub-villages.

Table 5 lists the contraceptive prevalence rates in the five provinces that were added to the VFP component beginning in late 1988.

Table 5
Contraceptive Prevalence Rates
in Five Additional Provinces

Province	1987 INCPS	1991 IDHS
East Kalimantan (II)	NA	57.9
Central Kalimantan (II)	NA	44.6
Irian Jaya (II)	NA	20.5
Maluku (II)	NA	43.2
Central Sulawesi (II)	NA	50.4

The 1987 INCPS provided provincial-level information only for the six Java-Bali provinces. Data for the 10 Outer Islands I were combined, indicating that prevalence was 41.7 percent for all methods. The comparable figure from the 1991 IDHS was 43.5 percent. Only four of the 11 Outer Islands II

provinces were surveyed in the 1987 INCPS which showed prevalence to be 39.6 percent. The comparable figure for the 1991 IDHS was 45.2 percent. The prevalence rate for all 11 Outer Islands II provinces in 1991 was 42.8 percent. Family planning now serves a majority of couples in most provinces.

KB Mandiri (Family Planning Self-Sufficiency). The concept of KB Mandiri was introduced by BKKBN as a way to encourage couples in both rural and urban areas to assume greater responsibility for family planning, including paying for services. The concept evolved as USAID encouraged BKKBN to consider privatization of family planning services and offered funds to introduce KB Mandiri in both rural and urban settings. Funds from the village family planning component enabled BKKBN to test the concept in rural areas. To enable more couples to become a part of family planning self-sufficiency, BKKBN has three levels of participation corresponding to the socio-economic level of the acceptors:

- Full KB Mandiri, under which couples pay fully for private family planning services and buy either commercial or social marketing Blue Circle contraceptives. ("Blue Circle" is the name selected by BKKBN for the new phase of fee-for-service family planning activities to be initiated through private doctors, midwives, and pharmacists — see Section 3.1.1.)

- Partial KB Mandiri, under which couples pay part of the costs of their contraceptive supplies.

- Pre-KB Mandiri active participation by poor families, but with free family planning services and contraceptive supplies from the government.

The initial KB Mandiri pilot rural project included the three provinces of Bali, Yogyakarta, and North Sulawesi and was funded under PIL 95. The University Research Corporation provided technical assistance for project design, implementation, data analysis, and evaluation under the Office of Population Asia Operations Research project. Additional technical assistance was provided through the Office of Population Family Planning Management Development project. The three provinces were chosen because of their extremely high rates of contraceptive prevalence (70 percent of eligible couples), strong provincial and lower-level family planning infrastructure, and strong expectation that KB Mandiri would succeed. The objectives of the project were to develop fee-for-service community-based distribution (CBD) systems, foster community financing of family planning, increase the use of private family planning services and contraceptives and expand the use of longer-term methods (intrauterine device [IUD], implant, and voluntary sterilization). The aim was to increase the percentage of couples who receive family planning services from the private sector from 20 percent to 35 percent over a two-year period, rather than focusing on increasing prevalence.

The major KB Mandiri interventions included preparation and distribution of information, education, and communication (IEC) materials for potential clients and participating doctors and nurse-midwives; training of family planning field workers, their supervisors, outreach workers, and community leaders to generate demand for private family planning services and longer-term methods and to develop community financing schemes; training of doctors and nurse-midwives; improving the BKKBN logistics to provide contraceptives for family planning field workers, supervisors, and outreach workers to initiate fee-for-service activities; and upgrading of the BKKBN management information system (MIS) to include indicators about use of private sector family planning services.

The final evaluations of the three-province pilot project indicated that large percentages of couples were paying for services, led by the injectable for which BKKBN has always charged a fee. In Bali, the shift to paying for services over the two-year period was from 25 percent of couples to 38 percent. The comparable figures for Yogyakarta indicated an increase in couples paying for family planning services from 13 percent to 39 percent. Results of the final evaluation of the North Sulawesi project are not yet available.

3.1.3 Problems Encountered

Difficulty in Measuring Impact in Low-Prevalence Sub-Districts. Although the project paper identified the low-prevalence sub-districts in each of the 13 priority provinces, the succession of BKKBN proposals and the resulting PILs relating to VFP did not allocate funds precisely for activities in those sub-districts. Rather, activities were specified for the provinces as a whole, and BKKBN's planning guidance encouraged provinces to give special emphasis to the low-prevalence sub-districts. Unfortunately, any effort to measure impact in the low-prevalence sub-districts is handicapped by the recently discovered inappropriateness of BKKBN service statistics as a measure of contraceptive prevalence (see Section 2). Also, since the 1987 INCPS did not measure contraceptive prevalence on a provincial level for the Outer Islands I and II provinces, there is no real baseline.

On the other hand, there is evidence that increased availability and accessibility of family planning service points lead to greater utilization and, overall, the number of service points did increase in all provinces. Thus, although it is not possible to assess the precise impact of project assistance in raising contraceptive prevalence in the low-prevalence sub-districts, it appears that USAID funds, as part of the total resources available in each province, contributed to increased contraceptive prevalence.

Lack of Clear Focus in KB Mandiri Effort. USAID provided technical assistance through several Office of Population contractors and funds to assist BKKBN in operationalizing the KB Mandiri concept so that it could become a significant element of the national family planning program. However, both the evolving nature of the KB Mandiri concept as it relates to public sector delivery of family planning services and the lack of clear operational guidelines to the field have made it difficult for local BKKBN staff to expand KB Mandiri efforts beyond the pilot project. Whereas the existing system has operated successfully for some years as a "free service" to village consumers, KB Mandiri requires some payment for services by most consumers. Nevertheless, both BKKBN and USAID are convinced of the value of the KB Mandiri approach and have included funds in the new Private Sector Family Planning Project to expand these efforts. Issues such as the amounts to charge for each contraceptive, who gets to keep the funds generated, and how to deal with persons who are unable to pay will be dealt with in the new project.

Delays Inherent in PIL Approval Process. The project implementation letter method was used for the more detailed descriptions of activities to be funded in each province or group of provinces. Typically, the process began with a joint BKKBN headquarters-USAID team visit to the province(s) to meet with provincial BKKBN and implementing unit leaders to devise an activities plan and proposed budget for the forthcoming year. Once officially reviewed and accepted by BKKBN headquarters, the BKKBN would send a request for assistance, containing details of the proposed activities, targets, and a budget. After USAID review, the PIL would be prepared and signed by both USAID and BKKBN.

Each PIL identified the activities to be undertaken and their time frames (usually one year to coincide with the Indonesian fiscal year). Funds were advanced for planned expenditures during the initial 90 days and replenished when vouchers were submitted. BKKBN submitted a final progress report on activities and a final financial report. These reports included information on the specific activities, new and continuing acceptors, the number of acceptor groups formed, number of persons trained, and number of village and sub-village family planning volunteers trained and added to the program. The general plan was to support activities in areas for only one or two years, until program costs could be incorporated into the BKKBN regular budget. Then project funds would be used to strengthen services in other areas.

Slowness in the PIL approval process created some delays in making funds available initially in several PILs. Once advances were made for the first quarter's activities, additional funds from USAID were made only upon receipt of vouchers from BKKBN. This created even more delays. Since vouchers had to move up the chain from sub-district to regency to province to BKKBN headquarters with processing time and mailing delays, succeeding tranches (or drops) would be delayed even longer. This put considerable financial strain on the local BKKBN offices, forcing them to reallocate available funds ("rob Peter to pay Paul") which often meant a slowdown of other planned activities to keep the USAID-supported activities moving.

These complications together with USAID's inability to adequately monitor the process led to a change in the final stages of the project. The GOI now provides funds for each activity and then applies for reimbursement from USAID. The new process became effective only in the last few months of the project. It is too early to determine whether this new process will help or hinder efforts to move funds to lower levels of BKKBN for implementation purposes. The PIL process was used for all components of the FPDS II project and each component reported similar concerns and problems.

3.2 Urban Family Planning Component

3.2.1 Component Objectives

The urban family planning component received $7,250,000 in USAID funds, $4,100,000 in grant funds and $3,150,000 in loan funds. At the time the project was designed, contraceptive prevalence in Indonesia's major cities was relatively low, according to BKKBN service statistics. The rate of urban population growth was increasing rapidly as rural residents moved to the cities, and the apparently lower urban contraceptive prevalence had serious implications for the continued success of the national family planning program. In 1980, the President of Indonesia urged BKKBN to give increased emphasis to the family planning needs of the urban population.

The component's general objectives were to develop urban family planning programs and promote the use of private providers (clinics, physicians, midwives, and pharmacies) in poor and lower-middle class areas. As the project matured, another fundamental objective emerged, though it was not explicitly stated. This objective was to establish and refine an urban family planning strategy — a comprehensive, coordinated approach to privatization and increasing urban prevalence. Flexibility was essential, as this strategy developed out of pilot efforts (such as the pioneering Dua Lima condom social marketing program carried out by the Office of Population SOMARC project) and experimentation with urban fee-for-service clinics by an Indonesian non-governmental organization, Yayasan Kusuma Buana (YKB), and expanded as BKKBN and the private sector designed new and

larger programs. As the concept of KB Mandiri (introduced in 1987) took hold, its implications for large-scale, long-term private sector participation represented a major policy shift and a new challenge to the public-private partnership.

Specific output targets for this component as established by the project paper include

- Developing urban family planning programs in the 10 largest cities in Indonesia (extended to 11 at the request of BKKBN); and
- Shifting 25-35 percent of current users to fee-for-service users (amounting to 4 million users).

Amendment 2 to the project paper added the following:

- Expanding the availability of a full line of contraceptives to 95 percent of the pharmacies at subsidized prices;
- Providing discount-priced contraceptives to 5,000 doctors and 8,000 midwives in private practice, 130 factory clinics, and 350 private maternities and clinics; and
- Making condoms available at over 20,000 patent medicine stores and other outlets.

Amendment 3 expanded the component to 10-15 additional cities.

Activities supported included a broadbased, two-phased Blue Circle training and information campaign targeted at both urban providers and consumers; training of physicians, midwives, and pharmacists; social marketing of Blue Circle contraceptives through the private sector; operations research; pilot tests of private sector delivery mechanisms; and organizational development assistance to non-governmental organizations (NGO).

3.2.2 Component Accomplishments

Use of Private Providers. From the broadest perspective, this component's success is demonstrated by the findings of the 1991 INCPS, which show that 22 percent of current users obtain their contraceptive method through private providers. This figure represents almost a 100 percent increase since 1987, when it was 12 percent. Private doctors and midwives account for two-thirds of this distribution. It is reasonable to assume that USAID and Office of Population support for the Dua Lima condom program, Blue Circle IEC activities, training of private providers, and technical assistance to help develop the program concepts, identify appropriate private sector groups, and organize the campaigns have had a major influence on this substantial shift to private sector utilization of contraceptives. It is unlikely that such a shift could have occurred without reasonably priced and widely available contraceptives, private providers motivated and trained to offer family planning services, and increased consumer awareness of private outlets and the Blue Circle line of contraceptives.

The Dua Lima condom sales program gave a new positive image to the condom as a respectable contraceptive for family use. It led to the expansion of the range of contraceptives available under the Blue Circle program and provided both BKKBN and private sector advertising and marketing companies with experience in contraceptive sales. Use of a resident technical adviser under local

contract played an important role in development of the Blue Circle training and information campaign, including training of private providers. Local firms were selected to create and manage the advertising campaign. Blue Circle product development followed on experience gained under the Dua Lima condom project, which utilized short-term consultants and a long-term resident technical advisor.

Integration of Mission and Office of Population Contractors and Central Funds. Another major accomplishment has been the integration of mission and Office of Population contractors and central funds for support of private sector activities. The technical advisor for the Dua Lima condom sales program and the initial phases of the Blue Circle program were supported by central funds through the SOMARC project. The Blue Circle training and information campaign was supported by central funds through the Population Communication Services project. The mission supported the Blue Circle contraceptive social marketing (CSM) training and program launch through a buy-in to SOMARC. This creative use of A.I.D. resources helped bring needed expertise to urban programming in Indonesia.

Blue Circle Products. From a programmatic standpoint, the component's activities have met or exceeded objectives established as the urban strategy was refined. The Blue Circle contraceptive social marketing program, initiated in 1988, now provides discount-priced Blue Circle contraceptives to private providers in 33 cities in 27 provinces and is expanding to 41 cities. A 1991 retail audit showed that 100 percent of the doctors, midwives, and pharmacists were aware of the products. The products were dispensed by 92 percent of the doctors, 94 percent of the midwives, and 100 percent of the pharmacists. Table 6 shows that the average monthly sales for all products have increased markedly:

Table 6
Average Monthly Sales of Blue Circle Products
(1989-1991)

Product	1989	1990	1991
Microgynon (strips)	28,000	61,000	100,000
Depo-Provera (vials)	75,000	148,000	180,000
Copper T (sets)	1,200	3,000	4,200
Condom Dua Lima (gross)	—	1,200	1,900

By October 1991, pill sales had reached almost 84 percent of the 1991 target. The corresponding figures for injectables, IUDs, and condoms were 61 percent, 86 percent, and 96 percent, respectively. Moreover, the participating manufacturers have made substantial financial investments in the Blue Circle program. This bodes well for long-term sustainability.

Blue Circle Training and Information Campaign. The Blue Circle training and information campaign, initiated in 1987 and coordinated by BKKBN, began in 4 major urban centers and expanded to 11 before its conclusion in 1989. Client and provider awareness and the shift of consumers to private providers indicate that the provider training programs were successful. Since project inception, the Indonesian Doctors Association (IDI) has trained almost 2,900 doctors to deliver family planning services and the Indonesian Midwives Association (IBI) has trained nearly 3,000 midwives. In addition, the Indonesian Pharmacists Association (ISFI) has trained more than 1,000 member

pharmacists. Manuals and other materials have been developed to support ongoing training of additional providers as BKKBN proceeds to implement its "301 Cities Initiative" which will expand the sales of Blue Circle contraceptives to the 301 largest cities of Indonesia, essentially all regency capital cities. Another 1,730 professionals are slated for training in 1991/92.

Effect on Private Sector Groups. In the implementation of diverse but complementary activities, this component has resulted in the establishment of linkages between BKKBN and a wide variety of private sector groups. It has also stimulated new linkages between the private sector groups themselves. Multi-organization planning and implementation task forces have been established nationally, provincially, and in target cities. In addition to BKKBN, participants include the associations of doctors, midwives, and pharmacists, as well as commercial companies responsible for selected aspects of program implementation (P.T. Mecosin KB as marketing manager, Survey Research Indonesia, contraceptive manufacturers, distributors, advertising firms, etc.). Although many of these relationships need further refinement and continued work is required to establish the most effective mechanisms for cooperation, these linkages have exposed BKKBN to new disciplines and new sources of expertise. In addition, they have laid the groundwork for future collaboration as BKKBN works with its private partners toward achievement of KB Mandiri.

3.2.3 Problems Encountered

Overall, the urban family planning component has been successful and has run relatively smoothly. At the same time, there are a few issues that have implications for USAID's follow-on Private Sector Family Planning Project.

Confusion about Meaning of Blue Circle. The original Blue Circle concept associated the Blue Circle logo solely with private providers and the Blue Circle products themselves. As the project evolved, BKKBN incorporated the logo into many of its own public sector family planning promotion messages. The Blue Circle logo has become a much broader symbol, used in sub-district health centers and other public facilities. There is evidence that consumers are confused as to what it really means. Research shows that some associate it with KB Mandiri, some with family planning in general, some with BKKBN, etc. While the high Blue Circle awareness is supportive of national family planning goals in general, it is unclear as yet how extension of the symbol will affect the long-term viability of the CSM program or private provider participation. Marketing success depends on brand recognition, and the value of the Blue Circle logo may be diluted. Also, private providers may become increasingly concerned that the symbol does not distinguish them from the public sector. Further, if the confusion affects sales of Blue Circle products, the manufacturers and distributors may conclude that continued investment and the supply of discount-priced contraceptives no longer makes good business sense.

This issue was raised as early as the 1989 midterm evaluation of the urban component, but there is no consensus as yet on whether it is a problem and, if so, how serious the problem is. BKKBN believes that extension of the symbol will not affect the CSM program. The Mecosin marketing managers suspect that it might, despite the continued sales growth to date. From a business and marketing standpoint, this concern is valid. Periodic, sharply focused research studies would help to define both the nature and magnitude of the problem.

Decrease in Efficiency Due to Participatory Management. That this component has marshalled the resources of BKKBN as well as private non-profit and for-profit organizations is evidence of the broadbased support for the family planning movement in Indonesia. The increasing participation of

these organizations indicates that the program meets their diverse interests. Nevertheless, there are growing pains associated with forging new alliances, and this project is no exception. Although various multi-organization task forces and coordinating groups have been established, some have obscured line responsibility for direction and control of selected operations, replacing it with less efficient participatory management and slowing the pace at which key decisions are made. As the project has matured, however, these problems have been reduced, and additional progress can be expected.

Inconsistencies between Public and Private Bureaucracies. One of the most challenging aspects of the urban component has been the establishment of working relationships between BKKBN and private organizations. In the process, it has become clear that there are substantial differences between public and private bureaucracies, and that these differences hamper selected aspects of program implementation. In addition, there are substantial differences between the private organizations, particularly the NGOs. The objective is to facilitate participation by the individual provider, yet providers may be caught between the inconsistent or incompatible regulations of BKKBN and their own professional associations. BKKBN has done a great deal to improve the regulatory environment for these providers. For example, doctors and midwives may now buy and sell Blue Circle contraceptives directly.

Questions about the Feasibility of Extending CSM Distribution beyond Large Cities. The commercial viability and ultimate sustainability of the Blue Circle CSM program depend largely on economies of scale. It is unclear how far distribution can be extended outside of the large urban areas before this distribution becomes too difficult and unprofitable for the private partners. Community-based distribution is one possible mechanism at the small town and village level, but the cost of moving goods to the point of pick-up by community-based distributors may be too great. Also, experience in other countries suggests that CBD workers may alter the pricing structure and thereby affect the sales of more formal traders. The feasibility of expansion (and its anticipated effects) needs further study, with considerable input from and analysis by the private partners.

Sales of "Free" Products by Government Doctors and Midwives. Staff, mainly Department of Health (DOH) providers from hospitals and health centers who are not under BKKBN control, sometimes sell "free" contraceptives in direct competition with the Blue Circle line of contraceptives. A BKKBN problem is leakage from storage facilities at every level. This poses a threat to the profitability of the Blue Circle products, thereby reducing the incentives to the private sector to continue promoting products with declining profitability. This will be a major concern affecting the success of the new Private Sector Family Planning project.

3.3 Voluntary Sterilization Component

3.3.1 Component Objectives

The voluntary sterilization (VS) component received $7,882,000 in grant funds. The initial objectives for the component were outlined in the 1983 project paper and covered the years 1983-1987 (Phase I):

- Upgrading of 173 provincial hospitals and 346 health centers to provide voluntary sterilization services in 13 priority provinces by providing funds for medical equipment and furniture, renovation of facilities, and training of medical staff;

- Support for the repair and maintenance (RAM) center for three years during the phase-over to GOI financial support; and

- Provision of technical and other assistance to the Indonesian Society for Secure Contraception (PKMI).

With the availability of additional funds, the following objectives were added in 1987 for Phase II (1987-1990):

- Upgrading of an additional 477 hospitals in the remaining 14 provinces as well as enough additional hospitals in the original 13 provinces to assure good coverage;

- Provision of training and orientation related to VS for staff of BKKBN and the Department of Health;

- Provision of international and local technical assistance;

- Establishment of a medical quality assurance system for all provinces to assure high-quality VS services;

- Development of a private VS clinic network; and

- Establishment of a VS reversal clinic.

3.3.2 Component Accomplishments

Renovation of Facilities, Provision of Equipment, and Training of Medical Teams. The VS component played a major role in expanding the availability of voluntary sterilization throughout Indonesia through renovation of facilities, provision of equipment, and the training of medical teams. The project also played an important role in strengthening PKMI to undertake training of medical teams, to develop, institute, and monitor quality assurance standards and patient counseling, and to promote VS under the policy guidance of BKKBN. It should be noted that VS remains a medical procedure and is not officially part of the national family planning program.

Specific component outputs were largely met. Although training of personnel was below expectations during the first phase, it was well above expected levels in the second phase. During preparation of the project paper, estimates were made of the number of hospitals and clinics likely to require renovation and equipment. The estimates were based on the number of facilities in each province and regency. During project implementation, two surveys of facilities were carried out by PKMI. On the basis of the more detailed information provided by these surveys, the number of facilities requiring renovation was determined and exact equipment requirements were established. These figures are somewhat lower than those used in the project paper.

During Phase I of the project (1983-87), 179 hospitals requested renovation as a result of the survey undertaken by PKMI; renovation was completed for 169 hospitals. An additional 39 hospitals received medical and non-medical equipment, but did not require renovation. Similarly, 238 clinics requested renovation; 230 were upgraded for VS.

Medical teams to be trained normally consisted of one doctor and two paramedicals. Plans called for training 269 hospital and 218 health clinic teams; 181 hospital and 71 health clinic teams completed training. The main reason for the lower numbers were slow transfers of funds from USAID, largely because of the slow process of gathering and processing vouchers through the GOI accounting system. Also, many facilities did not have enough vasectomy cases for the training groups.

Several important modifications were introduced during Phase II of the project. During Phase I, headquarters selected the hospitals to be renovated and equipped and staff to be trained based upon information available at headquarters. This proved to be an ineffective method of selection since there were important gaps in information on facilities, staff interest, and local cultural and religious concerns to consider. Local inputs were deemed essential in the selection process. During the Phase II needs assessment, PKMI provided its provincial offices with needs assessment guidelines and the provincial staff made the selections. A National VS Task Force was created with membership from PKMI, BKKBN, and the Department of Health. The task force provided overall direction and policy guidance for the project. PKMI was assigned responsibility for developing a needs assessment form that would enable a visiting team to quickly determine the amount of clinic renovation required, medical and non-medical equipment requirements, and staff training needs. PKMI was also assigned responsibility for developing and implementing medical training. The training was undertaken at PKMI training centers. Initially, nine PKMI training centers were utilized; by project end there were 11 training centers. BKKBN assumed responsibility for three aspects of facilities upgrading: renovation and procurement of both medical and non-medical equipment.

During Phase II (1987-90), 208 hospitals originally requested renovation based upon the PKMI survey and 211 hospitals were upgraded for VS. Training of medical teams greatly exceeded initial plans for 75 hospital teams and 236 health center teams. A total of 205 hospital teams and 260 health clinic teams received training. In addition, 1,060 counselors, 240 family planning field workers, 2,019 staff members of BKKBN and DOH, and 148 community leaders received training related to VS. A national VS reversal center was established in Jakarta and five additional VS reversal centers were established in the largest provinces (these latter with other donor funds).

Growth in Number of VS Procedures. The VS component has had a major impact on the availability of high-quality clinical services for voluntary sterilization and resulted in a substantial increase in the number of VS procedures performed annually. The number of VS procedures has grown steadily since 1974/75 when PKMI was established with assistance from the Association for Voluntary Surgical Contraception (AVSC). During the eight years of the FPDS II project, the number of VS procedures performed has expanded significantly (see Table 7 on the next page). It is of special interest to note the rapid rise in vasectomy procedures after the introduction of the "non-scalpel" method in the late 1980s and the substantial training program for doctors in vasectomy techniques carried out under the project.

Development of National Quality Assurance Program, Informed Consent Procedures, and Patient Counselling System. The VS component has had an important impact on the development of a national quality assurance program, having promoted and developed informed consent procedures and a patient counselling system to assure that clients are choosing VS voluntarily and with the knowledge that it is a permanent method of fertility control.

An initial pilot project on quality assurance in 1983 led to a four-province effort to train and orientate informal village leaders about VS. A five-day training course in VS for BKKBN and DOH

provincial and district staff in 13 provinces included information on both client counselling and temporary methods.

Table 7
Annual Number of Sterilization Procedures Performed
(1974/75-1990/91)

Indonesian Fiscal Year	Tubectomy	Vasectomy	Total
1974/75	7,724	1,959	9,683
1975/76	12,619	2,115	14,734
1976/77	19,020	3,487	22,507
1977/78	25,462	9,556	35,018
1978/79	32,425	7,444	39,869
1979/80	40,635	6,045	46,680
1980/81	49,839	5,306	55,145
1981/82	57,015	6,446	63,461
1982/83	70,595	18,861	89,456
1983/84	93,351	16,602	109,953
1984/85	83,916	7,054	90,970
1985/86	93,287	11,996	105,283
1986/87	88,128	8,343	96,471
1987/88	109,421	13,408	122,829
1988/89	102,123	24,259	126,382
1989/90	112,174	42,120	154,294
1990/91	100,480	45,441	145,921

Quality control teams have been established at three levels: an internal clinic peer review system; external provincial review teams (composed of representatives of BKKBN, DOH, and PKMI); and a national review committee (composed of members of BKKBN, DOH, and PKMI). The internal clinic peer review system remains a weak link in efforts to improve quality assurance since internal clinic review systems are not fully organized and operating in many facilities, and peer review is a new and threatening concept for many physicians. The external provincial teams meet monthly to review data on VS clinic performance. PKMI developed a clinic check list which is used for evaluation of quality assurance. BKKBN has budgeted funds to permit the provincial review teams to visit up to 30 percent of all VS clinics. These visits are used mainly to investigate VS clinics reporting higher than average rates of complications and failures. In an effort to improve quality assurance, the BKKBN monthly service statistics reports now include major and minor complications for all three clinical methods, VS, implant, and IUD. Since this information is available to each province about one month after the reporting month, the provincial external review teams are able to plan their visits

with timely data to guide the choice of facilities to be reviewed. The national review committee meets periodically to examine service statistics and recommend adjustments to program and policy.

The level of major and minor complications for VS are moderate by worldwide standards, a tribute to the training and quality assurance follow-up by PKMI.

As an example of GOI commitment to assuring that VS is voluntary, BKKBN has issued a policy statement, which is reinforced through its IEC program, that reversibility of VS cannot be used as motivation for VS. To emphasize the importance of quality assurance for clinical methods, a national meeting was organized and attended by representatives of BKKBN, PKMI, and DOH, followed by provincial meetings with representatives of the same institutions.

Counseling clients on VS has become an important element of the VS program to assure informed consent and volunteerism and as an element of good quality of services. Under the VS component, experts from the University of Indonesia's Department of Psychology were hired to develop materials for training doctors and support staff in counseling techniques. Project funds supported development of this counseling module and subsequent training programs which are carried out at 11 regional training centers. The VS counseling module has become the model for other BKKBN counseling modules on IUDs and implants.

Relationships between BKKBN, Department of Health, and PKMI. The VS component has also helped BKKBN, the Department of Health, and PKMI to establish closer working relationships and to reach agreement on the proper roles and functions of each organization. PKMI now provides all training in VS procedures and client counselling for DOH personnel and oversees the quality assurance program on behalf of the DOH and BKKBN. BKKBN has developed better working relationships with hospitals, local and provincial DOH staff, and PKMI as members of each organization have had to work together to plan project expansion and develop policies on quality assurance and medical standards. There has been a spillover of concern for quality assurance to other clinical methods, implant, and IUDs. Quality of services has become a much broader issue for all health services.

Establishment of VS Reversal Center. The VS component called for establishing one VS reversal center. Staff were trained and the center was established at Raden Saleh Clinic in Jakarta. PKMI helped establish standards and procedures and arranged for doctor training in Korea. Requests for reversal have been limited (perhaps 20 cases in three years).

3.3.3 Problems Encountered

High Cost of VS Procedures. Lack of money to pay for VS remains a barrier to many couples who might wish to utilize this effective means of fertility control. Although BKKBN subsidizes part of the cost of the procedure through reimbursements to providers, couples must provide the remaining cost of VS. This is particularly difficult for many poorer couples since it is an up-front cost. In limited cases in which VS has been offered free or at a low cost, demand is high.

Unmet Demand. Although the number of sterilization procedures performed since 1974 is impressive, there continues to be a significant unmet demand. Preliminary results of the 1991 IDHS indicate that half of currently married women of reproductive age do not want additional children. There is little difference between rural and urban women in their desire to terminate fertility. Even with only two living children, over half of currently married women want no more; the percentage

rises rapidly with higher parity. This makes them or their spouses prime candidates for VS. With the growth in the total number of couples of reproductive age, the percentage of couples protected by VS has remained at 3 percent between 1987 and 1991. In other ASEAN[1] countries at least 15 percent of couples have utilized VS. For Indonesia to reach this level would require a substantial increase in annual VS procedures. With all of the facilities now renovated and with trained staff, the need exists to examine some of the existing barriers, such as limited demand creation activities, lack of promotion, limited referrals by family planning field workers, and the high cost of the VS procedure. There is also a need to examine the seeming contradiction between the high percentages of women claiming that they want no more children and the low percentages of women and men choosing VS. Some of the potential market may have been taken by the rapidly expanding use of the long-acting implant contraceptive.

Lack of Information on VS. Lack of information on VS limits access to many couples wishing to terminate childbearing. According to the 1991 IDHS, nearly half of all married women of reproductive age did not know about VS and a similar percent did not know a source of information about VS.

Varied Clinic Utilization. Clinic utilization for VS varies widely. There are a limited number of clinics with high-volume VS practice. It is estimated that 20 percent of the clinics perform 80 percent of the sterilization procedures. However, many VS centers average less than 50 VS clients yearly, hardly enough for staff to maintain skills.

Frequent Transfers of Health Center Doctors. Frequent transfers of health center doctors mean a continual need for VS training to make VS services available and to maintain a high standard of service quality.

Dependence on Donor Resources. PKMI remains heavily dependent on donor resources and has not developed alternative sources of funding outside of BKKBN.

Expansion and Risks to Quality of Services. There is a continuing concern that the BKKBN push for expansion of services and increasing numbers of VS clients will lead to lower quality of services, with consequent long-term negative consequences for the VS program.

Slow Development of Hospital Internal Review Committees. The hospital internal review committee concept has been slow to develop although it is an integral part of the quality assurance program. Support for improvement in this area will be provided through the Private Sector Family Planning Project and the new R&D/POP Quality Control Project.

Limited GOI Funds. Limited GOI funds restrict provincial quality assurance teams' capability to monitor VS clinics fully.

Restrictions on Salary Levels of RAM Center Staff. Since BKKBN now provides funds for staff salaries at the RAM centers, these salaries must conform to GOI salary levels, thus staff motivation to remain is low. Also, since it is the DOH that has the clinics, the equipment, and the staff to provide VS, BKKBN priorities for repair and maintenance of equipment are not high. Some delays

[1]This is the Association of South East Asia Nations, a group of countries including Thailand, the Philippines, Singapore, Malaysia, and Indonesia. The group was formed in an effort to facilitate social and economic development within the region.

in repairing equipment have been noted and more delays are likely as services expand, especially if RAM staff are not maintained.

Inability to Establish Private VS Clinic Network. One element of the VS component was not completed. The project paper included plans for establishment of a private VS clinic network, relying mainly on existing maternity clinics. A needs assessment was carried out in five provinces. However, this project activity was halted because DOH regulations forbid maternity clinics to perform operations. No alternative mechanisms for establishing a private clinic VS network have emerged.

4. Strengthening BKKBN Institutional Capability

4. Strengthening BKKBN Institutional Capability

4.1 Modern Management Technology Component

4.1.1 Component Objectives

The objective of the modern management technology (MMT) component was to make computer technology widely available to BKKBN staff at headquarters and in the provinces in order to

- Improve data processing capabilities,
- Increase analytical skills,
- Improve financial management,
- Establish an historical data base at BKKBN,
- Expand access to data within BKKBN, and
- Improve personnel management.

The project initially provided $869,000 to assist the BKKBN to develop computer and word processing capabilities in 16 provincial BKKBN offices, the various bureaus at BKKBN headquarters, and in selected training and research institutions. The 16 provinces included the 6 provinces of Java-Bali and the 10 large provinces described as Outer Islands I. An additional $500,000 became available in the 1983 Amendment No. 1 to the project paper and was earmarked for additional computers, software, and training for the 16 provinces. Finally, Amendment No. 3 in 1987 provided another $500,000 for a minicomputer (to replace an outmoded model at BKKBN headquarters), software, training, and technical assistance. Minor shifts during project implementation brought total funding for this component to $1,948,000 including $1,348,000 in grant funds and $600,000 in loan funds.

4.1.2 Component Accomplishments

Computer Purchases and Computer Training. This component more than met the established project objectives. At the start of the project in 1983, the BKKBN had only a minicomputer at headquarters to process monthly service statistics reports on family planning activities and several other general reports. Operating units within headquarters had limited access to the data and limited opportunities to have computer time for their data analyses. Similarly, provincial BKKBN offices had no access to data or computers. Through the MMT component, headquarters and most provincial offices now have computers, staff trained in their use, and a ready access to data.

Computers and software were purchased and installed at 21 provincial headquarters. Only six small provinces with the least developed family planning programs were not included. BKKBN headquarters received 100 microcomputers which were distributed throughout the organization, including to the chairman and vice chairman, deputies, bureau chiefs, and bureau staff members. Training began with senior management to make sure that they understood the potential uses of computer technology for improving the operational, financial, and administrative management of BKKBN. Training then was provided to bureau chiefs and staff. A minicomputer was purchased and installed to replace the existing but outmoded model. The 24 regencies of West Java province received computers, software, and training in a pilot project to determine the utility and effectiveness of providing computer technology at lower administrative levels. A PBX telephone exchange was

purchased and installed to link the several buildings of BKKBN headquarters. Two staff members of BKKBN's Center for Computers and Data (PUKOM) received training in hardware maintenance and several staff members from operating units were trained in desktop publishing to enhance internal BKKBN capability to produce high-quality materials. Under the project a fund was established for technical support visits by PUKOM staff to provincial headquarters to conduct training and provide technical assistance. Procurement of a supply of computer spare parts has enabled PUKOM to quickly replace non-operating equipment.

Division of Responsibilities between Headquarters and Provincial Offices. BKKBN has developed several basic policies regarding the division of responsibilities between headquarters and provincial offices. The minicomputer at headquarters is used for centralized data processing, e.g., for operational reports involving some 4,000 sub-districts and 11,000 health clinics and employee data for the 40,000 BKKBN employees. Decentralized data processing is to be managed by each headquarters bureau for its own use, e.g., planning and financial data for the GOI budget processes by the Bureau for Planning and general accounting and tracking the nearly 200 separate BKKBN projects by the Bureau of Finance. PUKOM has prepared software packages for use by the provincial offices for analyzing service statistics data at the sub-district level, finance, logistics, training, personnel information, and field control. Evaluations every six months by PUKOM staff review provincial use of the computers and enable PUKOM to suggest changes in procedures or identify additional training needs to assure maximum utilization of the computers for program management.

Electronic Transmission of Data. The project provided funds to develop a system to enable the provinces to transmit data electronically to headquarters. It initially used modems, but now uses an "Electronic Communications System" through Intelsat. This has reduced data processing time at headquarters.

World Bank Funding. The success of the A.I.D.-supported MMT component has enabled the BKKBN to secure substantial funding from the World Bank. BKKBN has developed a master plan for distribution of microcomputers under which, ideally, there would be one microcomputer for each headquarters bureau, three for each provincial office, and one for each regency office. Under the new World Bank loan, funds are available for computers, software, and staff training for the 200 regencies encompassing the 6 Java-Bali and 10 Outer Islands I provinces. The Bank may provide funds for the additional computers, software, and staff training for the remaining 100 regencies.

Experience and Knowledge Sharing. PUKOM staff now lecture on the Indonesian experience with computers in the family planning program for the MIS courses offered by BKKBN's International Training Center, thus sharing their experience and knowledge with participants from other developing countries.

4.1.3 Problems Encountered

Need for Greater Numbers of Qualified Staff. Staffing for PUKOM remains a problem, primarily because of low salaries. There is a high demand in Indonesia for persons with computer skills. PUKOM is not able to compete and thus must deal with the reality of staff turnover. Finding persons with computer skills in the provincial capital also remains a serious problem. It affects the pace with which the modern management technology can be installed and utilized.

Dependence on Donors. GOI policies limit what BKKBN can supply for MMT through its regular budget, mainly funds for supplies and maintenance. BKKBN must rely on donors for computer

hardware and software. It appears that the World Bank will fill this requirement for much of the 1990s. No other solution is evident over the longer time frame except a change in GOI policy.

Need for Local Analysis of Service Statistics and Financial Data. Computers have been installed and operable at the provincial level for several years. Although it is clear that they have been utilized for more rapid transmission of service statistics and financial data to BKKBN headquarters, it is unclear the extent to which provincial staff have utilized the computers for local analysis of data for program management or research.

4.2 Training Component

4.2.1 Component Objectives

When this project was designed, Indonesia had only one school of public health and one demographic institute. In addition, there were insufficient numbers of BKKBN and implementing agency staff with appropriate baccalaureate and graduate degrees. The primary objective was to provide overseas long-term training, as well as long-term academic and in-service training in Indonesia. Some of these participants could then serve as faculty at new Indonesian training institutions. A related objective was to establish training management capability within BKKBN.

The project paper earmarked $5,095,000 for 56 masters and 16 doctoral degrees in the U.S., 90 masters and 14 doctorates in Indonesia, four specialized in-service training programs, and a special program for management development training. Amendment No. 1 provided an additional $1.4 million for 9 more masters degrees in the U.S. and four more in-service training programs. It also supported 40 short-term person months of training abroad. Amendment No. 2 in 1987 added $1.7 million for 30 more masters degrees in the U.S., contraceptive training for 5,000 DOH midwives implemented by the Bureau of Contraceptive Services in collaboration with the DOH, and a special orientation for 500 village family planning workers on male contraception and responsibility. Amendment No. 3 added $1 million for retraining of 20,000 village field workers and short-term international technical assistance for the development of BKKBN's International Training Center. It also allocated $400,000 in loan funds available through the 1986 devaluation to 60 in-country S1 degrees (baccalaureate degree). Minor funding shifts during implementation brought total funding for this component to $9,366,000, including $1,671,000 in grant funds and $7,695,000 in loan funds.

4.2.2 Component Accomplishments

Long-Term Training Targets. Some of the numerical targets above were modified through the PIL process. The number of U.S. trainees was raised to 135, with 121 masters and 14 doctoral degrees. The number of in-country graduate programs was decreased (to 56 S2 and one S3), and 200 S1 programs were added (the S1 roughly equates with the U.S. bachelor's degree, S2 with a master's degree and S3 with a doctoral degree). With regard to the training of midwives, the number was reduced from 5,000 to 2,500, and the length of the training program was increased from three to five days.

The following table compares planned and actual long-term fellowship awards and shows the number of degrees completed:

Table 8
Planned and Actual Fellowship Awards and Number of Degrees Completed

Degree	Planned	Actual	Completed	% of actual who did not complete training
Masters in U.S.	121	115	103	10
Doctorate in U.S.	14	12	7	42
S1 in Indonesia	200	248	148	40
S2 in Indonesia	56	53	20	62
S3 in Indonesia	1	1	0	100

The number of S1 awards is higher than planned because the project provided support to some people already enrolled in study programs. Thus, some of the fellowships were considerably shorter than others, and more awards could be made. In the other categories, the number of awards is quite close to the targets. However, the completion rates (percentages of trainees receiving degrees) are disappointing. As pointed out in the *Impact Evaluation of BKKBN Training Activities, 1984-1990*, the corresponding figures for overseas training programs at the Department of Education and the Office of Overseas Training (BAPPENAS) are 2.8 percent and 0.8 percent respectively.

Short-Term Training Targets. All of the short-term training targets were met, with family planning training for 2,500 midwives, training in male contraception for 500 field workers, and retraining of 20,970 field workers in KB Mandiri. Nine short courses were provided for 161 participants, 12 of whom work at the provincial level and the remainder at BKKBN headquarters. Topics included management, research methodology, computer testing and measurement, the English language, library science, personnel screening, and job analysis. Trainees report high levels of satisfaction with these programs.

Institutionalization of Training Management Capability. Considerable progress has also been made regarding institutionalization of BKKBN's training management capability. Systems are in place to assess training needs and to develop an overall training plan. This plan is essentially a "grid" which indicates how slots are allocated to each office, echelon, specialty area, etc., and what kind of training is attached to each slot. In addition, selection criteria have been established indicating candidate age, academic prerequisites, and other requirements. There is a system for advertising fellowships, securing nominations, and selecting candidates, a process that takes about three months. There is also a system for monitoring candidates while in training through telephone calls and submission of semester grade reports, but this has not been uniformly effective with participants overseas. Virtually continuous long-term international technical assistance has been provided to the national training center (PUSDIKLAT) to assist in developing and institutionalizing the systems and skills needed to manage the training program.

International Training Center. The BKKBN has established an International Training Center which now offers a selection of courses to participants from other developing countries. The courses focus on organization and management of family planning programs with special emphasis on those aspects of family planning services in which BKKBN excels, such as village family planning, contraceptive

logistics, and utilization of multiple ministries in a national program. Participants are funded mainly by USAID missions.

4.2.3 Problems Encountered

Inadequate Training Completion Rates. The completion rates are clearly a matter of concern, particularly with regard to the expensive overseas component. They suggest the need for some improvements in the recruitment and selection process. According to the impact evaluation, 57 percent of the men and 62 percent of the women were "assigned" for training, whereas only 39 percent and 35 percent respectively took the initiative to apply. Of those enrolled in in-country degree programs, many complained that they were unable to complete their degrees because they were working at the same time. Modified recruitment and selection procedures might minimize these kinds of problems.

Inefficient Overseas Participant Monitoring Mechanisms. The established overseas participant monitoring mechanisms require the cooperation of the participants. It is hard to follow up on those who do not submit semester grade reports. In addition, it is difficult to uncover problems by long-distance telephone, and to assist participants in resolving these problems before they interfere seriously with the course of study. Modified monitoring procedures might reduce the number of participants who fail to earn their foreign degrees. A.I.D. generally requires U.S.-based monitoring of all participants studying in the U.S., but this project has never complied with that requirement.

Need for Continued Reliance on Long-Term Advisors. The role of a long-term expatriate advisor has been crucial to assist BKKBN in all aspects of overseas participant training. The new World Bank loan supports overseas training in the U.S., Europe, and Australia. Coordination of overseas training requires knowledge of different educational systems as well as the ability to manage a highly complex operation. It is unlikely that sufficient capability has been institutionalized within PUSDIKLAT. BKKBN has indicated that it may seek World Bank support for another expatriate long-term advisor. An alternative would be to secure internships for PUSDIKLAT staff in local organizations that have well-developed overseas training program management systems, such as the Overseas Training Office at BAPPENAS or NGOs like The Asia Foundation.

Lack of Match between Training and Job Responsibilities. According to the *Impact Evaluation of BKKBN Training Activities, 1984-1990*, 78 percent of those who studied overseas reported that their fields of study matched their present job requirements, but the figure was only 50 percent for those who studied in Indonesia. Over 90 percent in both groups reported a high level of interest in their programs, but only 60 percent reported high educational benefits (i.e., increased capacity to perform the job). In the family planning field, this figure was only 33 percent. A related finding was that half of the S2 candidates studying in Indonesia returned to positions unrelated to their field of study. The same was true for over one-fifth of those who studied in the U.S. Given the high costs of long-term training, especially overseas, greater correlations between training and job responsibilities would be desirable. Despite the personal educational benefits perceived by trainees, reported relationships between fields of study and job content are much lower and do not represent a maximum return on investment. It may be helpful for BKKBN to review its general policy of job rotation and develop methods to place returning trainees in positions more relevant to the fields of study in which participants enroll.

4.3 Research Component

4.3.1 Component Objectives

The general objectives of this component were to institutionalize research capacity within BKKBN's Bureau of Research and to generate research studies and disseminate findings useful to the national family planning program. The project paper obligated $1.9 million for technical assistance, staff training, and research activities. Another $1 million was added in 1987 to fund additional technical assistance, a 1990 INCPS, and support to the National Center for Child Survival. Output targets established in the project paper include

- 25 biomedical, operations, and social science research projects and support for the 1985 national intercensal survey,
- 12 seminars and workshops on topics related to population research methodology, and
- 12 conferences and meetings to disseminate research findings.

As the project progressed, support was transferred from the intercensal survey to the 1987 INCPS and subsequent 1991 IDHS.

4.3.2 Component Accomplishments

Research Projects Completed. BKKBN leadership has long had a strong interest in research, especially research that helps strengthen and expand family planning services and helps identify problems and test solutions. Numerical targets have been exceeded. Fifty-one research projects have been completed, along with the 1987 INCPS. One of the research projects involved 16 secondary analyses of the INCPS. Approximately 60 percent of the research studies are contracted out and the remainder completed in-house. There were 26 seminars and workshops and 26 conferences and meetings for dissemination. One-day meetings are now held twice a year to present research findings to provincial offices. In addition, a research findings newsletter was developed and distributed, and abstracts of research projects were prepared for dissemination.

In terms of capacity development, this component has benefited from expatriate and local technical assistance as well as in-house and external staff training. Approximately two-thirds of the research unit's professionals received overseas training during the project period, though not all of them were supported by project funds. One earned a doctorate. Examples of in-house training courses include SPSS (Statistical Program for the Social Sciences) multivariate analysis, research methods, operations research, and qualitative methods. Staff report that in-house capability in surveys has increased over the life of the project. In addition, they report a wider range of linkages with other organizations, both producers and users of family planning research.

Center for Child Survival. Initial funding from the research component supported establishment of the Center for Child Survival, a research center affiliated with the University of Indonesia. The Center undertakes research on a broad range of issues concerning health and fertility issues and has played a leading role in focusing attention on remaining problems of high infant and child mortality in Indonesia.

4.3.3 Problems Encountered

There have been two extensive studies of the research component. The first was a midterm evaluation conducted in February 1988. The second was a follow-up analysis and plan of action in November 1988. The evaluation noted several areas of weakness, including research management, research quality, staffing (both quantitative and qualitative), planning and priority setting, selecting and implementing a research focus, administration, and interaction with the provincial offices. It also noted that progress had been made in some areas during the project's first five years. These kinds of problems were confirmed in the detailed follow-up analysis, and the plan of action recommended a series of options to be considered by BKKBN in strengthening its research unit. The analysis made a clear distinction between barriers that cannot be removed (such as the tripartite division of the research function) and those that can. The plan of action suggested a four-part strategy: improving the management systems (personnel and research), increasing staff skills, focusing on priority research areas, and clarifying the division of responsibility among the three centers. The plan has not been implemented by BKKBN, and most of the key problems remain.

Staffing Difficulties. In terms of numbers, the research unit is seriously understaffed. In addition, some of the existing staff have been away in long-term training programs. Further, high levels of expertise are few and far between, and many of the higher-level positions are vacant.

Inefficient Administration. USAID provided support for the creation and operation of three research centers under the BKKBN's Program Development Division, beginning in 1984. These three research centers are the Center for National Family Planning Policy (PUJAK), the Center for Biomedical and Human Reproduction Research (PUBIO), and the Center for National Family Planning Studies (PUSIK). Each of the three centers has its own administrative apparatus. This is inefficient and was so recognized in the midterm evaluation and the plan of action developed in 1988. Both recommended strengthening BKKBN's Office of the Deputy for Program Development by creating a secretariat to assume some of the administrative functions of the three centers and serve as the mechanism for assuring that research findings are widely distributed. The recommendation has not been implemented.

Inadequate Coordination between Operational Units and Research Unit. Although the research unit has worked with the operational units, the latter continue to maintain their own research capability and conduct their own studies. There is a feeling that "operational" knowledge and sensitivity are required to conduct operational program research, and the operational units feel that they are better suited to it.

Poor Quality of Extramural Research Proposals. The evaluation report noted the poor quality of the extramural research proposals funded. BKKBN suggested in its comments on the evaluation that those Indonesian institutions with the capacity to generate good quality proposals can apply directly to donors and do not need to go through BKKBN. Nevertheless, the research unit is still not qualified to implement all of the research programs and must contract some of them out. Some mechanism is needed to improve the quality of these proposals.

Unclear Work Focuses. The research focus is still poorly defined, as are the differences between the population and policy research centers.

5. Lessons Learned

5. Lessons Learned

5.1 Privatization of Family Planning Services and Social Marketing

Privatizing family planning services seems to work best when initiated on a small scale in a limited market with a few contraceptives and then expanded to a wider market with a broader array of contraceptives based upon the initial experience.

The BKKBN has taken a pragmatic approach to expanding private sector participation in the delivery of family planning services. Social marketing of contraceptives in Indonesia developed rapidly in the 1980s with A.I.D. financial and technical support and BKKBN policy and leadership support. The program began in Jakarta and a few other large cities. The target consumer market and the delivery mechanisms were identified. Early studies of consumers provided baseline data to design the Dua Lima condom sales program in some large cities. The system was tested and results analyzed and utilized for the next stage of expansion. Development of the Blue Circle IEC program provided experience in training private sector service providers and in designing appropriate publicity materials. Necessary policy changes were identified and acted upon to permit public advertising of Blue Circle contraceptives and to allow private providers to distribute and sell those contraceptives. Once the policy changes had been approved, the Blue Circle products were launched in the market.

Social marketing campaigns tend to be most successful when the private sector experts are allowed to make market decisions. At the same time, private sector providers require substantial stimulus to encourage their participation.

There appears to be a large market in Indonesia for family planning services delivered through the private sector. Data from the 1987 IKNS and the 1992 IDHS showed a dramatic increase in couples choosing to get their family planning supplies through the private sector — from 12 percent of all current users in 1987 to 22 percent in 1991. Enabling the private sector to meet the potential demand has not been a simple task, and the task is far from complete. It has involved substantial training for private providers, changes in government regulations to permit private providers to distribute and sell contraceptives and to permit brand name advertising of contraceptives, and retraining government family planning workers and volunteers to support the shift to the private sector. This is a lengthy process and thus far has been focused only in the larger metropolitan areas. Extending private sector family planning services to smaller cities and rural areas may take substantially longer because of lower incomes, availability of fewer private providers, a more dispersed clientele, and the uncertainty of adequate financial return to providers.

Social marketing can utilize existing systems of family planning service delivery as well as previously existing but unused or underutilized delivery systems.

Contraceptive social marketing is nearly as old as BKKBN itself. The village family planning concept is based primarily on social marketing, convincing village couples (women mainly) to practice family planning to produce "small, happy, and prosperous" families and having the contraceptives and information available at the village level. The activities under this project have supported BKKBN efforts to involve the private medical practitioners in providing family planning services on a fee-for-service basis and to begin to convert the village family planning network from an essentially free distribution system to one that recovers some or all of program costs.

5.2 Long-Term Methods

A large number of service points with trained staff is essential for widespread use of most long-term methods. The exception appears to be voluntary sterilization, where higher quality of service in a limited number of service points may be a more important factor in increasing the number of clients than a large number of service points.

Acceptance of longer-term contraceptive methods is growing rapidly in Indonesia. IUDs have always been an important element within the national family planning program and continue to be a popular method, especially in certain provinces such as Bali. During the past eight years, the implant has moved from clinical trials to an approved contraceptive in Indonesia. The implant is highly popular and the number inserted annually continues to show large increases. Voluntary sterilization continues to grow in popularity, especially vasectomy with the introduction of the "no-scalpel" method. VS continues to be a medical procedure and is not officially part of the national family planning program. With USAID support, nearly 900 facilities were renovated and equipped and staff trained to provide VS. Currently about 20 percent of the facilities provide about 80 percent of the VS procedures. The need now is to survey the low-performing clinics to identify the problems that limit their services.

5.3 Improvement in Quality of Services

Establishing a sound quality assurance system is a long-term process with a substantial training component to meet the specific needs of professionals at each organizational level. The most difficult level at which to introduce a quality assurance monitoring system is the individual hospital or clinic where peers are reviewing and monitoring performance of peers.

Experience in Indonesia with quality assurance for VS indicates that establishing the national and provincial-level review committees was comparatively easy. Establishing clinic-level peer review committees has proved a more daunting task and the committees will take some years to become functional.

6. Contributions of the Project to Indonesia's National Family Planning

6. Contributions of the Project to Indonesia's National Family Planning Program

6.1 Political Commitment to the National Program

Political commitment to the national family planning program has been unusually strong in Indonesia since the early 1970s. Although the project has had little direct impact on the political commitment of Indonesian leaders to the program, continued support from USAID has enabled the BKKBN to undertake new programs, such as KB Mandiri and expansion of voluntary sterilization, to demonstrate to the people of Indonesia and to the political leadership that high-quality family planning services can be available to all couples. Similarly, USAID support for modern management technology, training, and research aimed to improve the institutional capability of BKKBN to manage an increasingly large and complex national program. BKKBN's ability to do so is necessary to ensure continued strong commitment and support of the political leadership.

6.2 Family Planning Policy Development

The project has played an important role in assisting BKKBN in the development and implementation of two aspects of family planning policy: privatization of family planning services and improvement in the quality of services.

At the time the FPDS II project was authorized, the BKKBN had announced plans to develop an urban strategy to respond to the different needs and conditions in the urban areas. The urban family planning component was designed to support what was anticipated to be an evolving urban program. The previous bilateral project had provided funds for surveys of men and women in Jakarta to gain an understanding of their fertility and family planning requirements. This was followed by initial funding from Office of Population contractors for development of several fee-for-service clinics managed by YKB and the Dua Lima condom sales program. Additional Office of Population funds were provided for the development of the Blue Circle IEC campaign. The FPDS II project provided funds to train doctors, midwives, and pharmacists in family planning methods and for marketing the Blue Circle line of contraceptives for sale through these private providers. Concurrently, the village family planning component provided funds to initiate KB Mandiri activities in several provinces to test the acceptability to rural families of beginning to pay for contraceptives after two decades of free services.

The rapid expansion of voluntary sterilization services created concern over maintaining a high quality of services to deflect any criticism of the program on grounds of poor medical care. Under BKKBN leadership and under the technical guidance of PKMI, funds from the voluntary sterilization component and from AVSC with Office of Population financial support, a system of national, provincial, and hospital committees has been established to monitor the program. This commitment to quality assurance is now part of BKKBN policy. Similar policies are being developed for the other long-term clinical methods — implants and IUDs.

6.3 Demographic Impact

Since the A.I.D. resources are integrated into the larger programs of BKKBN, there is no way to measure the demographic impact of A.I.D. funds alone. Given the multitude of factors that influence fertility, it is difficult enough to measure the impact of the national family planning program on fertility. Earlier studies indicate that the program has been a major contributor to the overall fertility decline in Indonesia over the past 20 years. During that period, total fertility fell from 5.6 to 3.0 children per married woman of reproductive age.

6.4 Sustainability

There is no question of the sustainability of the national family planning program. Political support is stronger and more publicly demonstrated in Indonesia than in most countries. Surveys indicate that most couples recognize the need to reduce fertility; over half of all married couples are currently using a contraceptive method; the total fertility rate continues to decline; family planning services are becoming more widely available through a greater variety of public and private providers; and couples show increased willingness to pay for services. The BKKBN is a comparatively well-organized bureaucracy with an annual budget of over the equivalent of $100 million and a staff of 40,000 employees supplemented by 300,000 village and sub-village family planning volunteers. As the coordinating body, BKKBN utilizes the facilities and expertise of other government agencies to support and implement family planning programs. Donor resources supplement those of BKKBN and enable the national program to expand more rapidly than would be possible with domestic resources alone and to test new approaches. The great majority of resources, however, are Indonesian.

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7. Conclusions

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7.1 General

7.1.1 Sustainability of BKKBN's Family Planning Program

The GOI has continued to provide ample funds, staff, and policy support to BKKBN to enable it to oversee an expanding national family planning program. Substantial funding from A.I.D. and other donors has enabled BKKBN to expand programs faster than would have been possible with GOI funds alone. Indonesia has developed its own contraceptive production facilities for all major methods except the implant and is no longer dependent on donor funding for this key element of any family planning program. Thus, the prospects for sustainability of Indonesia's national family planning program are exceptionally good. The new emphasis on fee-for-service will reduce the government's budget burden and increase individual involvement and commitment to the program through purchase of contraceptives.

7.1.2 Fertility Reduction

Indonesia is well on its way toward achieving replacement level fertility within the next decade. Fertility is declining to an average of 3.0 children among all cohorts of Indonesian women of reproductive age. More than 50 percent of all currently married women of reproductive age want no more children and five provinces have already achieved replacement level fertility (2.1 children or less).

7.1.3 Private Sector Family Planning Services

A.I.D. has been the only donor organization interested and willing to provide funds to expand private sector family planning services. The rapid increase in the share of couples seeking contraceptive services through the private sector between 1987 and 1991 offers good evidence of the potential for this market. The new Private Sector Family Planning project will continue USAID support for private sector family planning into the mid-1990s.

7.1.4 Family Planning Policy

The project contributed to several important policy changes by the GOI:

- Authorization for doctors and midwives to sell and dispense contraceptives. When the Blue Circle IEC campaign was launched, doctors and nurses were not allowed to sell or dispense contraceptives. Continuation of this ban would have effectively killed the planned introduction of Blue Circle commodities and use of doctors and midwives as the primary distributors.

- Authorization to advertise Blue Circle contraceptives by brand name through the mass media. This has helped establish Blue Circle products as market leaders.

- Development and implementation of a multi-tiered system of quality assurance for voluntary sterilization. The system provides rapid feedback to PKMI, BKKBN, and

MOH on complications and helps remove some of the threats to the VS program by assuring the public and policy leaders that VS is a safe and carefully monitored program.

7.1.5 Working Relationship between USAID and BKKBN

USAID and BKKBN recognition that the bilateral family planning project was part of Indonesia's national family planning program and was not viewed as a "USAID project" helped create a collaborative working relationship.

7.1.6 Role of Technical Assistance Advisors

Long-term technical assistance advisors have played an important role in most of the project components to assist with project implementation and transfer of technical skills to Indonesian counterparts. However, greater recognition needs to be given to developing self-reliance within BKKBN and upgrading BKKBN staff capabilities. Of particular interest is what needs to be done to develop BKKBN expertise to manage donor-supported activities and prepare requests for funds and periodic reports. Responsibility for assuring the successful transfer should be shared by the advisors and the BKKBN.

7.1.7 A.I.D. Technical Assistance Capability

A.I.D. has a unique (among donors) capability to provide technical assistance quickly, either through A.I.D. worldwide contracts and grants or through USAID contracts. The availability of additional resources through Office of Population worldwide contractors and grantees for technical assistance and operational activities has enhanced USAID's ability to support BKKBN in development of new program initiatives. (See Appendix E for a brief description of major buy-ins and centrally funded projects that have contributed to project implementation.)

7.1.8 USAID Funding and Program Flexibility

USAID financial and program planning and reporting documentation have grown more cumbersome over the years and make the assistance more burdensome to the BKKBN. Concerns have been raised by BKKBN leadership that USAID is becoming less development oriented and more accounting oriented. Additional accounting requirements have led to delays in processing funding requests and have increased BKKBN concern that USAID procedures and projects will be less flexible to meet requirements of a dynamic and changing program.

7.2 Village Family Planning

7.2.1 Quality of Baseline Data

There is a need for better baseline data in setting project objectives in order to carefully assess the results. This has been partially met by the 1991 IDHS and plans to continue similar surveys at regular intervals in the future.

7.2.2 Shift of Financial Burden for Family Planning Services from Government to Individuals

The Indonesian initiative to shift the financial burden for family planning services from the government to individuals is unusual. Most countries have attempted to expand private sector participation because of the low level of government support for public sector family planning services. In Indonesia, a successful public sector program exists. The various activities to shift the financial burden merit careful documentation, not only for Indonesia but for other countries to examine.

7.3 Urban Family Planning

7.3.1 KB Mandiri

The BKKBN's policy of KB Mandiri is taking hold although there is still confusion over the policy's exact meaning at various operational levels. There appears to be great potential for expansion of the concept in both urban and rural areas although the approach may be somewhat different -- utilizing the commercial sector and private providers in urban areas and private providers (village midwives) in rural areas where the vast network of village family planning volunteers may be shifted over time to selling rather than distributing contraceptives. The percent of couples purchasing contraceptives through the private sector nearly doubled between 1987 and 1991 and now represents 22 percent of current contraceptive users.

7.3.2 Expansion of CSM Program

BKKBN's push to have Mecosin expand the CSM program to 301 cities may increase costs to the point where it is no longer profitable for the private sector to participate.

7.4 Longer-Term Methods

7.4.1 Voluntary Sterilization

The MOH, BKKBN, and PKMI could be more aggressive in promoting VS to reach the apparent large unserved market, consistent with internal cultural and religious constraints. The number of VS procedures has grown steadily over the past decade; however, the increase during the past several years has been due to a rapid increase in vasectomy while tubectomy has reached a plateau. The total number of VS procedures annually appears to fall far short of potential demand based upon responses to the 1987 and 1991 prevalence surveys. The BKKBN has far more budget capability to subsidize VS procedures than is currently utilized.

7.4.2 Implants

Contraceptive implants are the fastest growing method now used in Indonesia. However, all aspects of the implant program face serious medical issues. There is a need for a PKMI-equivalent organization in the area of implants to train medical staff in insertion and removal, set standards,

standardize training and medical procedures, develop evaluation procedures, monitor quality assurance, and provide technical assistance.

7.5 Modern Management Technology

7.5.1 Utilization of Computer Capability

Utilization of computer capability at provincial and regency levels to analyze data for program management, administration, or monitoring purposes is still low. Training in computer utilization for program managers at these levels would encourage them to make productive uses of data already at their command.

7.5.2 Data Analysis and Quality of Data

There is as yet no direct way to measure impact in this area. The component provided the capability and capacity to improve data analysis and apply results of analysis to management and administration of family planning programs. There exists a continuing concern with the quality of data reported through BKKBN's monthly service statistics collection system.

7.6 Training

7.6.1 Long-Term Graduate Level Training

Although it is impossible to link training to project performance (i.e., increasing prevalence), it would be helpful to study possible links between long-term graduate level training and increased work responsibilities and promotion within BKKBN. However, exposure to new ideas and concepts was generally held to be beneficial by trainees and BKKBN leadership and opportunities for training, especially in the U.S., are generally sought after.

7.6.2 Staff Upgrading

There is a continuing need for BKKBN staff upgrading, particularly as the program deals with new concepts such as KB Mandiri and emphasis on the private sector.

7.7 Research and Development

7.7.1 Research Capability

Research capability at the Bureau of Research appears low. Despite the presence of some staff with graduate academic training, there are many vacant positions, especially at higher levels within the office. Other areas of weakness include research management, research quality, planning and priority setting, and coordination with the operating units and the provincial offices.

The Bureau of Research will not likely fulfill its important role within BKKBN unless staffing is improved in quantity and quality and the other issues described above are resolved.

7.7.2 Research Outputs

Research outputs were achieved or exceeded in terms of numbers of studies completed. However, the role of the Bureau of Research within BKKBN as a source of analysis is limited. Other operating units have funds for research and it is not clear what role the Bureau of Research plays in these research activities.

The planning and management of research within BKKBN are scattered and not coordinated in a manner that would achieve more effective utilization of funds and limited technical staff.

8. Recommendations

8. Recommendations

Staying the Course

1. USAID should continue to provide assistance in the future to the Indonesia family planning program in areas of mutual interest with BKKBN. Such assistance could play an important part in helping Indonesia reach its desired demographic goals over the next decade

Village Family Planning

2. USAID should consider offering limited technical assistance to assist BKKBN in documenting current efforts to shift the financial burden for family planning services from the government to individuals.

Urban Family Planning

3. Future USAID assistance should continue to support expansion of CSM initiatives in the larger urban areas through technical assistance, training, and substantial support for program activities, especially local currency costs of advertising, promotion, and marketing of products. The urban sector of the Indonesian national family planning program offers the greatest opportunity for continued USAID assistance. The BKKBN's policy of stimulating greater participation of private providers in promoting family planning matches current A.I.D. policy. Work initiated under this project has only begun to tap the resources of the Indonesian private sector.

Voluntary Surgical Contraception

4. USAID should continue to provide technical assistance in the areas of quality assurance, expansion of services, and increasing the use of private sector physicians. Given the substantial investment in this sector by A.I.D., it makes good sense to continue support to this vital program component.

Quality Assurance for Implants

5. It is essential that BKKBN and the Ministry of Health establish for implants an independent organization, similar to PKMI for voluntary sterilization, to establish standards of care, provide field surveillance, develop peer review committees, assist in training of providers, and monitor program implementation. This is the single most important area for improved quality assurance in the Indonesian program.

Modern Management Technology

6. USAID should consider using funds for limited technical assistance in modern management technology in the future as new opportunities for greater use of computers are identified or to assist in the evaluation of current computer programs. There is no more than a limited role for future USAID assistance in this area now that the World Bank loans are covering the costs of additional hardware and software.

Training

7. USAID should fund expatriate technical expertise to assist BKKBN staff in management of overseas training, but only if USAID plans to be a major provider of long-term overseas training; otherwise the technical assistance should be provided by the World Bank or other major donor. Any future assistance should be conditioned upon improvements in the existing selection processes and internal BKKBN procedures which have lead to much higher non-completion rates than other Indonesian government overseas training program.

8. USAID should encourage BKKBN to provide more short-term training to staff in new areas such as KB Mandiri and privatization of services.

Research

9. USAID should provide some technical assistance and long-term training for staff of the Bureau of Research, but only after BKKBN has developed a plan to coordinate the management of research.

10. USAID or an A.I.D. contractor should consider funding continuing research on several current problems, such as field studies to test implementation of KB Mandiri and investigation of the causes of the slow growth in contraceptive prevalence between the 1987 and 1991 surveys.

Appendices

Appendix A

Scope of Work for Evaluation

Appendix A

Scope of Work for Evaluation

I. **Background:** the Family Planning Development and Services II project was initially implemented in 13 of Indonesia'S 27 provinces. It was begun in June 1983 and current PACD is December 31, 1991. Through three project amendments, there is an A.I.D. funding of $36.4 Million ($19,2 Million Grant and $17,2 Million Loan), also GOI contribution = $76,866,000. The original goal of the project to reduce the annual birth rate in Indonesia to between 22 and 23 births for every 1,000 members of the population by 1990. The project sought to achieve this goal by increasing the contraceptive prevalence rate, the percentage of married women between 15 and 44 years of age using contraceptive methods, from 43 percent in december 1982 to 56 percent by March 1987. In June 1987, a project amendment raised this target to 65 percent by March 1989. However, the 1987 National Indonesian Contraceptive Prevalence Survey (NICPS), indicated that contraceptive prevalence was actually 48 percent at the end of 1987. Service statistics indicated 67 percent prevalence. Acknowledging the gap between independent survey findings and its service statistics, the BKKBN is now examining ways to refine its service statistics data system and is institutionalizing the periodic prevalence surveys to independently corroborate results. The BKKBN, in its 1982-94 five year plan has reduced its contraceptive prevalence objective to 50% by 1992 and 53 percent by 1994.

II Scope of Work.

1. Measurement of accomplishments of project objectives for the six components of the project.

A. The evaluation will assess the expansion and improvement of <u>family planning services</u> as regards to the following planned activities:

- Expansion of Village Family Planning Services in the 13 high priority provinces and in additional low and high prevalence provinces on a pilot basis ($1,299,000 Grant; $5,755,000 Loan).

- Development of Urban Family Planning programs in 11 major cities, with special emphasis on utilization of the private sector and cost-recovery activities, including the ongoing social marketing program and expansion to other major cities ($4,100,000 Grant; $3,150,000 Loan).

- Upgrading the quality of Voluntary Sterilization (VS) services and developing a private sector voluntary sterilization network ($7,882,100 Grant).

B. The evaluation should finalize the impact of the project on strengthening of BKKBN institutional capability to plan, manage and evaluate its program through:

- The introduction of Modern Management Technology ($1,369,000 Grant; $600,000 Loan), with special emphasis on automated MIS to all provinces, nationwide service statistics and logistics system.

- Training in-country and overseas, long and short-term training related to family planning management and technical skills improvement ($1,650,000 Grant; $7,965,000 Loan).

- Research and Development support to measure program progress, test new ways of delivering information and services, study interrelationships between family planning and child survival, and strengthening of research management systems ($2,900,000 Grant).

2. In addition to the immediate project objectives the evaluation should assess other impacts:

A. Identify lessons learned from the project which can/are being applied to USAID's current private sector FP project (Project 0355), particullary in the aspects of privatization of services, social marketing, long-term methods and improvement of quality of services.

B. Analyze the contribution(s) of this project to the overall national family planning program, i.e. contribution to political commitment for family planning, FP policy development, demographic impact and sustainability).

III. Timing of the Assessment. November, 1991 (3 weeks)

IV. Evaluation Team.

The team should be composed of two expatriate consultants (with Indonesian experience preferred) and one local expert, who have a balanced mix of family planning program experience, demographic analysis and evaluation skills. The should be headed by a team leader who has, in addition, strong writing skills and a demonstrated ability with quickly translate team member contributions into an integrated draft report. Proposed team members are as follows:

A. Expatriat consultant:

1) Team leader- family planning program evaluation experience, management
   - strong writing skills,
2) demographer/program evaluation experience and skills.

B. Local consultant:

- Demographer will program analysis skills

In addition, USAID is requesting a team member from AID/W (ST/POP) to add strength in either clinical family planning delivery, training and/or program evaluation (total team = 4 persons).

V. Required Reports.

A rough draft of the team's report including a summary of the evaluation major findings conclusions, and recommendation will be prepared for Mission review before the team leader's departure to permit discussion, and clarification. The team will present a final verbal briefing to USAID and to the National Family Planning Coordinating Board.

A final written report (3 copies) should be provided to the Mission within 30 days of completion of this assignment. This report will include a Summary of Evaluation Findings, Conclusions and Recommendation which will address the following Items:

- Purpose of evaluation and methodology used
- Purpose of activity(ies) evaluated
- Findings and conclusions (related to questions).
- Principal recommendation
- Lesson learned

Appendix B

List of Documents Studied

Appendix B

List of Documents Studied

1. USAID/Jakarta. Project Paper, Family Planning Development and Services II, Project 497-0327. June 1983.

2. USAID/Jakarta. Project Paper Supplement (Amendment #1). July 1983.

3. USAID/Jakarta. Project Paper Amendment #2. May 1987.

4. USAID/Jakarta. Project Paper Amendment #3. August 1987.

5. Afandi, Biran, Roy Jacobstein, Firman Lubis, and Alan Margolis. *Midterm Evaluation of Voluntary Sterilization Component.* Population Technical Assistance Project, Arlington, VA, August 1989.

6. Bair, William D., Ida Bagus Astawa, Kemal Nazaruddin Siregar, and Diddy Sudarmade. *Evaluation of Village Family Planning Program, 1983-1986.* Population Technical Assistance Project, Arlington, VA, July 15, 1987.

7. Harbison, Sarah, Sri Djuarini, and Dewa Nyoman Wirawan. *Midterm Evaluation of USAID Project 497-0327, Research Component.* February 1988.

8. Bair, William, James Echols, Suprijanto Rijadi, and Julie Marsaban-Sterling. *Evaluation of the Urban Component of Family Planning Development and Services II.* Population Technical Assistance Project, Arlington, VA. July 18,1989.

9. Gueron, Joseph, Deal Salpini, Janice Brodman, and Firman Siregar. *Final Report: Midterm Assessment of the Modern Management Technology Component.* October 5, 1988.

10. Hoedojo, Lina G. Padma. *Comprehensive Assessment of BKKBN Education and Training Program.* 1986.

11. Poerbonegoro, Soeratmi, and Lexy J. Moleong. *Impact Evaluation of BKKBN Training Activities 1984-1990 Under Project FPDS II.* Jakarta, Indonesia. December 1990.

12. Indonesia National Contraceptive Prevalence Survey (1987).

13. Preliminary Report of the Indonesia Demographic and Health Survey (October 1991).

14. Midterm Report, KB Mandiri Village, Bali, Yogyakarta and North Sulawesi (August 1990).

15. World Bank, Country Department V, Asia Regional Office. *Indonesian Family Planning Perspective in the 1990s.* Washington, D.C. January 30, 1990.

16. Pusat Penelitian Pranata Pembangunan, Lembaga Penelitian Universitas Indonesia. *Evaluasi Proyek Pilot MIS BKKBN Daerah Tinkat II Di Jawa Barat, 1989/1990.* 1990.

17. Update on MMT Activities, Memorandum from James Filgo, February 28, 1991.

18. Reynolds, Jack, James Villalobos, and Andrew Kantner. *Research Management and Staff Development: A Plan of Action for the Program Development Division of BKKBN.* November 1988.

19. Bahman, Vahidi, James Johnson, Sri Djuarini, and Omastik. *The Assessment of the Distance Learning Program (PJJ) of BKKBN.* July 1989.

20. USAID Project Implementation Letters for each Project Component.

21. USAID Regional Inspector General/Audit, Manila. *Audit Report of Family Planning Development and Services II, Project Number 497-0327, Audit Report No. 2-497-89-01.* October 5, 1988.

22. Accountability Report, Central Committee of PKMI, 1988-1991 Commission Period (August 1991).

23. BKKBN. *Action Plan for USAID Assistance, April 1, 1989 - December 31, 1991.* BKKBN Division for Program Development, Jakarta, Indonesia. June 30, 1989.

24. Sumarsono, Sudibyo Alimoeso, and Srihartati P. Pandi. *Analysis of the 1987 National Indonesian Contraceptive Prevalence Survey: Implications for Program Evaluation and Policy Formulation.* Paper prepared for presentation at the Demographic and Health Surveys World Conference, August 5-7, 1991, Washington, D.C.

25. Poedjastoeti, Sri and Sri Harijati Hatmadji. *Fertility Decline in Indonesia: Analysis of Fertility Intentions.* Paper prepared for presentation at the Demographic and Health Surveys World Conference, August 5-7, 1991, Washington, D.C.

26. Dwiyanto, Agus. *The Demand for Family Planning in Indonesia 1976 to 1987: A Supply-Demand Analysis.* Paper prepared for presentation at the Demographic and Health Surveys World Conference, August 5-7, 1991, Washington, D.C.

27. USAID/Jakarta. *Private Sector Family Planning Project Paper.* August 10, 1989.

28. Allen, Carl, and Mark Lediard. *Assessment of IKB-SOMARC Project: A View After Three Years of Program Implementation.* IKB-SOMARC Project Indonesia, Jakarta, Indonesia. March 16, 1989.

29. P.T. Mecosin and The Futures Group. Blue Circle Market Research Workshop, August 22-23, 1991. Jakarta, Indonesia.

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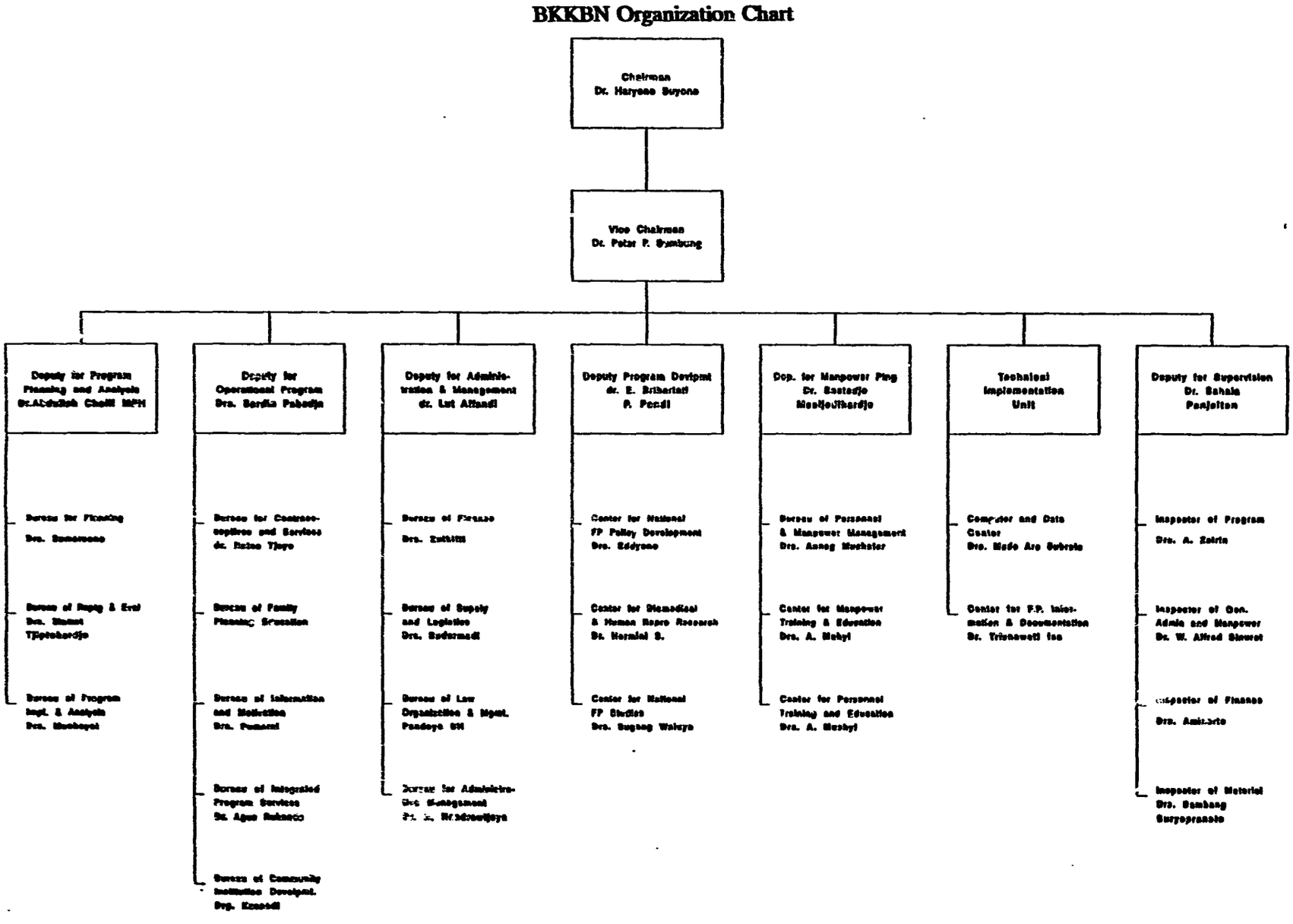
31. Mitchell, Marc D. *Indonesia Pilot Project Activities for KB Mandiri Pedesaan. Final Report April 1989 - September 1990.* Management Sciences for Health for the Family Planning Management Training Project.

Appendix C

BKKBN Organization Chart

Appendix C

BKKBN Organization Chart



Appendix D

Financial Summary
Family Planning Development and Services II

Appendix D

Financial Summary
Family Planning Development and Services II

Data as of September 30, 1991
(US $000)

Component	Obligated	Disbursed	Accrued	Pipeline
Village family planning - grant	1,299	833	139	327
Village family planning - loan	5,755	5,560	96	99
Urban family planning - grant	4,100	3,554	539	7
Urban family planning - loan	3,150	2,823	15	312
Vol. Steril. - grant	7,882	7,243	346	293
Mod. Mgmt. Tech. - grant	1,348	1,323	53	(28)
Mod. Mgmt. Tech. - loan	600	594	0	6
Training - grant	1,671	1,594	58	69
Training - loan	7,695	7,462	93	140
Research & Dev. - grant	2,900	2,424	131	345
Total - grant	19,200	16,921	1,266	1,013
Total - loan	17,200	16,439	204	557
TOTAL	36,400	33,360	1,470	1,570

USAID projects total expenditures by December 31, 1991, to be $35,550,000 and expects to deobligate $850,000 at the end of the project.

Appendix E

Major Buy-Ins and Centrally Funded Projects

Appendix E

Major Buy-Ins and Centrally Funded Projects

- Urban Family Planning. The Dua Lima condom social marketing project was undertaken with S&T/POP funds through SOMARC. As opportunities expanded and BKKBN policy developed, the Blue Circle IEC campaign was launched, utilizing S&T/POP funds through the Population Communication Services project for the services of a short-term technical advisor. A long-term expatriate technical advisor was hired with USAID bilateral funds and S&T/POP contractors provided funds for the campaign itself. Ultimately, the Blue Circle product launch was financed with bilateral funds through a buy-in to SOMARC and included a long-term technical advisor.

- The Asia Operations Research project, managed by the University Research Corporation with S&T/POP funding, provided funds and technical assistance for studies, such as pricing policy, to guide the development of BKKBN's community-based contraceptives distribution initiative.

- AVSC funds and technical assistance helped establish PKMI in 1974 and facilitated its development thereafter. With the initiation of the VS component under FPDS II, USAID arranged a buy-in to AVSC for a long-term resident technical advisor, short-term consultants, and procurement of equipment for VSC clinics.

- The Family Planning Management Training project provided a long-term technical advisor to assist in the management of overseas training and development of BKKBN's institutional capability to provide international training.

- The Demographic and Health Survey project provided technical specialists to assist in planning, implementing, and analyzing the results of the 1987 INCPS and the 1991 Indonesian Demographic and Health Survey.

- The East West Center's Demographic Data Initiatives project provided extensive technical assistance for secondary analysis of IDHS data.